Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES OWENS AINSWORTH
2. Date of Death Month Day Year: JANUARY 1 1997
3. Time of Death: 7 15 PM
4a. Facility Name (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: HAVRE de GRACE
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 213 01 0603
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 1, 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: ABERDEEN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 222 CURTIS STREET
10f. Zip Code: 21001
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 YRS. | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad): GENERAL FOREMAN
16b. Kind of Business/Industry: CROWN, CORK + SEAL

17. Father's Name (First, Middle, Last): HARRY AINSWORTH
18. Mother's Name (First, Middle, Maiden Sumama): LILLIAN OWENS

19a. Informant's Name/Relationship (Type, Print): BARRY S. AINSWORTH
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 CARION COURT LOCKEYSVILLE MARYLAND 21030

20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): STATE ANATOMY BOARD
Date: JAN 6 1997
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8300 HARFORD ROAD - PARKVILLE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failiure. List only one cause on each line.

Approximata Intarval Batween Onset and Death

Immediate Causa (Finai diseasa or condition resulting in death): e. Congestive heart failure — Approximata Intarval: 12 hours
Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in daath) Last:
b. Dua to (or as a consequence of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Type II Diabetes; Emphysema

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Unpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Rasidance 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledga, death occurred at the tima, data and place, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and piace, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] CLERIC MD
29c. Licensa number: D31712
29d. Date signed (Month, Day, Year): 1/2/97

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECCLES 219 W. BELAIR AVE. ABERDEEN, MD 21001

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FilmG743 item 5 per FH 1-15-97 rja

Certificate of Death

Reg. No. 97 00002

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH M. ALLERS
2. Date of Death: Month JANUARY Day 2, Year 1997
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): 200 CHEDDINGTON ROAD
4b. City, Town, or Location of Death: LINTHICUM
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security: ~~820-02-4067~~ 217-26-0881
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
6. Date of Birth (Month, Day, Year): APRIL 21, 1905
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 200 CHEDDINGTON ROAD
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:
14. Raca - American Indien, Black, White, etc. Specify: WHITE

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6TH GRADE; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOMEMAKING

17. Father's Name (First, Middle, Last): FREDERICK WIENER
18. Mother's Name (First, Middle, Maiden Surname): MARY KRUMPLEMAN

19a. Informent's Name/Relationship (Type, Print): BETTY T. HABERKORN(DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 CHEDDINGTON ROAD - LINTHICUM, MD 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN CEMETERY
Dete: 1/4/97
20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Jackie N. Shannon
22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	1day
Due to (or as a consequence of): b.	Coronary Artery Disease	10 yr
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last — Due to (or es a consequenca of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema
Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as steted. 2☐ Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to tha cause(s) and manner stated.

29b. Signeture and title of certifier:
29c. License number: D25044
29d. Dete signed (Month, Day, Year): 1/2/97

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): DR. MALIK REHMAN - 2717 HAMMONDS FERRY ROAD - BALTIMORE, MD 21227

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00003

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANTHONY P. ADAMS
2. Date of Death Month Day Year: JANUARY 1, 1997
3. Time of Death: 16:14
4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-5024
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG 7, 1924
9. Birthplace *(State or Foreign Country)*: BALTIMORE, MD

Usual Residence of Decedent

10e. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5000 LEEDS AVENUE
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PURCHASING MANAGER
16b. Kind of Business/Industry: AMERICAN CAN COMPANY

17. Father's Name *(First, Middle, Last)*: ANTHONY ADAMS
18. Mother's Name *(First, Middle, Maiden Surname)*: CONSTANCE MESIVICHUS

19a. Interment's Name/Relationship *(Type, Print)*: MARY CAMPBELL (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 ANDERSON RIDGE ROAD - CATONSVILLE, MD. 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOST HOLY REDEEMER
Date: 1/4/97
20c. Location - City or Town, State: BALITMORE

21. Signature of Funeral Service Licensee: ▶ Jackie D. Shannon
22. Name and Address of Facility: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardiac Arrythmia — 1 Hour

Due to (or as a consequence of):
b. Ischaemic Heart Disease. — 6 years

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. End stage congestive Heart failure. — 6 years

Due to (or as a consequence of):
d. Heart Block. — 6 years.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cancer of colon
Cancer of Prostate

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*:
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mohammad Saleem MD
29c. License number: D40610
29d. Date signed *(Month, Day, Year)*: January 1, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMAD SALEEM ST. AGNES HOSP. E.R.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

97 00004

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN F. BURCH SR				2. DATE OF DEATH (Month, Day, Year): January 2, 1997	3. TIME OF DEATH: 8:22 M
4. SOCIAL SECURITY NUMBER: 214-14-1296	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 7, 1921	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST Joseph's Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Co Md		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore Md	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2809 Westfield Ave		10f. ZIP CODE: 21214	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 TH; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ESS-LINE	16b. KIND OF BUSINESS/INDUSTRY: BREWERY	
17. FATHER'S NAME (First, Middle, Last): LEROY Burch		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY WACHER	
19a. INFORMANT'S NAME (Type/Print): IRENE Burch	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2809 WESTFIELD AV. BALTO MD 21214		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD Cem.	DATE: 1/6/97	20c. LOCATION — City or Town, State: BALTIMORE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jody D. Smith	22. NAME AND ADDRESS OF FACILITY: HARTLEY MILLER FUNERAL HOME 7527 HARFORD Rd BALTO MD 21234		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardio Renal Vascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles O'Donnell MD	29c. LICENSE NUMBER: D-09383	29d. DATE SIGNED (Month, Day, Year): ▶ 1-2-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Charles O'Donnell - St Joseph's Hospital		
31. DATE FILED (Month, Day, Year): JAN 03 1997	32. REGISTRAR'S SIGNATURE: Gloria Berman-Randall	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00005

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CONSTANCE BROOKS
2. Date of Death Month Day Yaer: JANUARY 1,1997
3. Time of Death: 8:55 AM
4a. Facility Name *(If not institution, giva street and number)*: SAINT JOSEPH MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON,MARYLAND
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-09-1121
6. Sex: 1☐ M 2☒ F
7. Age *(in yrs. last birthday)*: 85 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: July 14, 1911
9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidanca of Decedant

10a. Stata: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Hillendale
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Straat and Number: 6920 Donachie Road
10f. Zip Coda: 21239
10g. Citizan of What Country?: United States

11. Marital Stetus: 1☐ Navar Merriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad
12. Wes Dacedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Datas:
13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Spacify:* White

15. Decedent's Education *(Spacify only highast grada compiatad)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):
18a. Dacedant's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT usa retired)*: Social Worker
16b. Kind of Businass/Industry: Government

17. Fether's Name *(First, Middle, Last)*: Samuel Cirincione
18. Mother's Nama *(First, Middla, Maiden Surneme)*: Rosalie Messineo

19a. Informant's Name/Ralationship *(Type, Print)*: Ms. Rosalie A. Brooks/Daughter
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 206 Twin Oaks Road Linthicum, Maryland 21090

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Place of Disposition *(Nama of cematery, cramatory or othar place)*: Most Holy Redeemer Cemetery
Data: 1/4/97
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funaral Sarvice Licensaa: Brian A. Willem
▶ Brian A. Willem
22. Nama and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Pert1. Enter tha disaasa, or complications thet caused tha death. Do not antar tha mode of dying, such es cardiec or respiretory errest, shock, or haart failura. List only ona cause on aach lina.

Approximete Interval Batween Onset and Death

Immediata Causa (Finat disaasa or condition resulting in daath)
e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — UNKNOWN

Due to (or as a consequance of):

Sequantially list conditions, if any, leeding to immediata causa. Entar Underlying Cause (Diseesa or injury that initiated evants resulting in daath) Last
b.
Dua to (or as a consequenca of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was casa rafarred to medical axaminer? 1☐ Yas 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Hama 5☐ Rasidanca 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, data and plece, and dua to tha causa(s) and mennar as statad. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, deta and pieca, and due to tha causa(s) and mannar stated.

29b. Signature and titla of cartifiar: ▶ Eduardo P. Layug
29c. Licansa number: D24025
29d. Data signad *(Month, Day, Year)*: JANUARY 1, 1997

30. Neme and address of person who complated causa of daath (item 23a) (Type, Print): EDUARDO LAYUG, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 03 1997
32. Registrer's Signature: Lilia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Bessie Cooper

2. Date of Death (Month, Day, Year): January 2, 1997

3. Time of Death: 1:30 AM

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford County

Funeral Director

5. Social Security Number: 236-02-3414

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 8, 1920

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: WV

10b. County: Pendleton County

10c. City, Town or Location: Seneca Rocks

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15 Bowers Trailer Court

10f. Zip Code: 26884

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Jacob Teter

18. Mother's Name (First, Middle, Maiden Surname): Lucy Lamb

19a. Informant's Name/Relationship (Type, Print): Mrs. JoAnn Watts (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Bowers Trailer Ct., Seneca Rocks, WV 26884

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cooper Family Cemetery

Date: 1/4/97

20c. Location - City or Town, State: Seneca Rocks, WV

21. Signature of Funeral Service Licensee: Brian L. Haight

22. Name and Address of Facility: Haight Funeral Home for Schaeffer FuneralHome P.O. Box 195 Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Parietal Brain Tumor — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ischemic cardiomyopathy

Renal failure on hemodialysis

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D37517

29d. Date signed (Month, Day, Year): January 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David C. Rubin 104 Plumtree Rd Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997

32. Registrar's Signature: Lia Davidson-Randall

To be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ITEMS: 17. & 18. PER F.H. FILM
g-743 1/10/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00007
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joann L. Dolle
2. Date of Death: Month: January Day: 1 Year: 1997
3. Time of Death: 3:30 P.M.
4a. Facility Name (If not institution, give street and number): 5611 Patrick Henry Drive
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218 52 3325
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4,1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5611 Patrick Henry Drive
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Tele Marketing

17. Father's Name (First, Middle, Last): DANIEL C. SMITH ~~William Creighton~~
18. Mother's Name (First, Middle, Maiden Surname): MARY CREIGHTON ~~Grace Elizabeth Darrell~~

19a. Informant's Name/Relationship (Type, Print): Grace McCartney / sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 528 Pembrooke Court Millersville, Maryland 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 1/4/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: ▶ Jerome Gonce
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Cancer
Due to (or as e consequenca of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyelcian**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Markan M.D.
29c. Licanse number: D39505
29d. Date signed (Month, Day, Year): Jan. 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yndhish Markan. 1406-B Crain Hwy #202 Glen Burnie MD. 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella J. Dimpel

2. Data of Daath — Month: January; Day: 2; Yaer: 1997

3. Time of Death: 11:00 A.M.

4a. Facility Name (If not Institution, give street and number): 5710 Magie Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 163 14 6487

6. Sax: 1☐ M 2☒F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 3, 1914

9. Birthplace (State or Foraign Country): Pennsylvania

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 5710 Magie Street

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed)

Elementery/Secondery (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Businass/Industry: Restaurant

17. Fathar's Name (First, Middla, Last): John Skerbetz

18. Mother's Name (First, Middle, Maiden Sumama): Mary Drop

19a. Informant's Name/Relationship (Type, Print): Kathleen Smith / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 5710 Magie Street Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cematary, crematory or othar place): Jefferson Memorial Cem.

Date: 1/6/97

20c. Location - City or Town, State: Pittsburgh, Penna.

21. Signature of Funeral Service Licensee: ▶ Jerome Zgamierski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO MYOPATHY — 5yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were sutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was cesa referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: ▶ K. Dharmasena, M.D.

29c. License number: D17753

29d. Data signed (Month, Day, Year): 1/3/1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K.S.DHARMASENA, M.D. 710 CHURCH ST. BALTO. MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha burial-transit permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00009

Reg. No.

ITEM:8 perFH G-743 1-10-97 eoh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EDNA ESTELLE GOETZ	JANUARY 1, 1997	3:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
216 N. EDGEWOOD STREET	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-07-6927	1☐ M 2☒ F	82 Yrs.			~~DEC~~ OCT 3,1914	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
216 NORTH EDGEWOOD STREET	21229	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8TH GRADE		SUPERVISOR	MANUFACTURING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ARTHUR CHANEY	ESTELLE ENGLEHART

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JEAN GOETZ(SISTER-IN-LAW)	216 NORTH EDGEWOOD STREET - BALTIMORE, MD 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	LOUDON PARK CEMETERY	1/4/97	BALTIMORE

21. Signature of Funeral Service Licensee: ▶ Jackie D. Shannon

22. Name and Address of Facility: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic gall bladder cancer	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul R. Gormley MD	D18587	JAN 2 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. PAUL GORMLEY - 900 CATON AVENUE - DEPT OF ONCOLOGY - BALTO., MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 03 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josephine V. Gosnell

2. Date of Death: Month January Day 1 Year 1997

3. Time of Death: 2:00 P.M.

4a. Facility Name (If not institution, give street and number): 4106 Doris Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 234 26 7241

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 26, 1910

9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4106 Doris Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Howard Meredith

18. Mother's Name (First, Middle, Maiden Surname): Grace Grove

19a. Informant's Neme/Relationship (Type, Print): Mary Jo Niec / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4106 Doris Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Memorial Park

Date: 1/4/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Jerome Fromuowitz

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
a. Bronchogenic Carcinoma — 2 Months

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GLAUCOMA

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Richard E. [illegible] MD

29c. License number: D02519

29d. Date signed (Month, Day, Year): Jan-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Richard Fisher 4710 Pennington Ave Balto., Md 21226

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur Hillary

2. Date of Death — Month: January Day: 1 Year: 1997

3. Time of Death: 13:09

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N A

Funeral Director

5. Social Security Number: 217-05-7175

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/26/02

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 2095 Rock Rose Ave.

10f. Zip Code: 21214

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Artie Shaw-Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 861 Park Ave. Baltimore, MD 21201

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. Zion Cemetery — Date: 1/3/97

20c. Location - City or Town, State: Lansdowne MD

21. Signature of Funeral Service Licensee: ▶

22. Name and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Respiratory Failure

Due to (or as a consequence of):

c. Urinary Tract Infection

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one) — Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. Diaz III MD MEDICAL HOUSE OFFICER

29c. License number: 89269

29d. Date signed (Month, Day, Year): 1/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gervacio Diaz III, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00012

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Heard

2. Date of Death Month: January Day: 1 Year: 1997

3. Time of Death: 10:00 PM

4a. Facility Name *(If not institution, give street and number)*: Liberty Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-22-3840

6. Sex: 1☒ M 2☐ F

7. Age *(in yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2-16-26

9. Birthplace *(State or Foreign Country)*: Baltimore, MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1000 N. Gilmor St.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 10-16-44 8-38-46

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Neme/Relationship *(Type, Print)*: Lavern Heard - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2501 Harlem Ave. Baltimore MD 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Veteran

Dete: 1/6/97

20c. Location - City or Town, Stete: Crownsville, MD

21. Signature of Funeral Service Licensee ▶

22. Neme end Address of Feclity: Albert P. Lylie F/H PA 638 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. Liat only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Carcinoma of Lung

Due to (or as a consequence of):

b. Cerebrovascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopay performed? 1☐ Yes 2☑ No

24b. Were autopay findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Plece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and dua to the cause(a) and menner steted.

29b. Signeture and title of certifier: ▶ George E. Wicks III M.D.

29c. License number: D41365

29d. Dete signed *(Month, Day, Year)*: January 1, 1997

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): George E. Wicks III 2600 Liberty Heights Ave. 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 1997

32. Registrer's Signature: Julie Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00013

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Daisy HUghes
2. Date of Death: Month Jan. Day 1, Year 1997
3. Time of Death: 3:00pm
4a. Facility Name *(If not institution, give street and number)*: 8349 OLd Philadelphia Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-20-2422
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 12,1904
9. Birthplace *(State or Foreign Country)*: MAryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8349 Old Philadelphia Road
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line
16b. Kind of Business/Industry: Bendix Corp.

17. Father's Name *(First, Middle, Last)*: Yado
18. Mother's Name *(First, Middle, Maiden Surname)*: Hanna Parrel

19a. Informant's Name/Relationship *(Type, Print)*: Timothy Blair
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 60 Yew Road Baltimore Md. 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Holly Hill Cemetery — Date: 1/4/97
20c. Location - City or Town, State: Baltimore MD.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Arteriosclerotic coronary vascular disease	4 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

atrial fibrillation
polymyalgia rheumatica
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D29197
29d. Date signed *(Month, Day, Year)*: 1/2/97

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): J. M. WIETHOFF 9000 FRANKLIN SQUARE DR BALTO, MD. 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 3 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00014

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Edward Johnson
2. Data of Death Month: JANUARY Day: 2 Yaer: 1997
3. Tima of Death: 8:16 Am
4a. Facility Nama (If not institution, giva street end number): Harbor Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Deeth: N/A

Funeral Director

5. Social Security Numbar: 212 56 4359
6. Sex: 1☒M 2☐F
7. Aga (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov. 19, 1950
9. Birthplaca (Stata or Foreign Country): New York

Usual Rasidance of Dacedant

10a. Stata: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒Yes 2☐No
10e. Street and Number: 923 Herndon Court
10f. Zip Coda: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒Never Marriad 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armad Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 1☐Yes 2☒No Specify:
14. Rece - Amaricen Indian, Black, Whita, atc. Specify: White

15. Dacedent's Educetion (Specify only highast grada completad)
Elementery/Secondery (0-12): 8th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Cook
16b. Kind of Business/Industry: Restaurant

17. Fethar's Nama (First, Middla, Last): (Unknown)
18. Mothar's Nama (First, Middle, Maidan Surneme): Dorothy Johnson

19a. Informant's Name/Ralationship (Type, Print): Charles Johnson
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 126 Cedar Hill Road Baltimore, Maryland 21225

20a. Method of Disposition: 1☐Burial 2☒Cramation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)
20b. Placa of Disposition (Name of cematery, cramatory or othar placa): Metro Crematory, Inc.
Dete: 1/3/97
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Jerome Zgonnowski
22. Nama and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or haart faidre. List only ona ceusa on aach lina.

Approximate Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. Complications of AIDS — years

Dua to (or es a consequenca of):

Sequantially list conditions, if eny, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated evants resulting in daeth) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consaquance of):
d.

Part II. **Other aignificant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐**Yas** 2☑**No** 3☐**Probably** 4☐**Unknown**

24a. Wes an autopsy performed? 1☐Yas 2☑No

24b. Ware autopsy findings available prior to completion of ceusa of daath? 1☐Yas 2☑No

25. Was cesa referrad to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one)
Hospital: 1☑Inpatiant 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Homa 5☐Rasidence 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury (Month, Dey Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1☑**Certifying Physician:** To the best of my knowledga, deeth occurred at tha time, date and place, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signatura and titla of certifiar: ▶ James Horodyski, MD
29c. License number: AS249161 4
29d. Deta signed (Month, Day, Year): January 2, 1997

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print): James Horodyski 3001 S. Hanover Street, Baltimore, MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997
32. Registrars Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn Knepp

2. Date of Death Month Day Year: 01 - 02 - 97

3. Time of Death: 2'15 pm

4e. Facility Name (If not institution, give street and number): Long View Nursing Home

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-28-6899

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 25, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2504 Burridge Road

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 3rd

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): William Frick

18. Mother's Name (First, Middle, Maiden Surname): Adelaide J. Dell

19a. Informant's Name/Relationship (Type, Print): Lois Foard /daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2504 Burridge Road Baltimore MD. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery

Date: 1/6/97

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 week

Due to (or as a consequence of): Aspiration — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Subdural hematoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D33165

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Stauffer MD 8111 Kenwood Pike Hampstead MD 21074

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00016

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MINNA P. KEELEY

2. Date of Death Month / Day / Year: JANUARY 1 1997

3. Time of Death: 3:55 PM

4e. Facility Name *(If not institution, give street and number)*: RIVERVIEW NURSING CENTRE, INC

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-20-6212A

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2-20-1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 530 N. Robinson Street

10f. Zip Code: 21205

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Crown Cork & Seal

17. Father's Name *(First, Middle, Last)*: Raymond Mattson

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Dieffenbach

19a. Informant's Name/Relationship *(Type, Print)*: Raymond Petty

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 208 S. Fagley Street Baltimore, Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn Cemetery

Date: 1/4/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Marcia N. Zannino

22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St. Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC HEART DISEASE — UNKNOWN

Due to (or as a consequence of):

b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HISTORY PULMONARY EMBOLUS, COPD, DEMENTIA, MYOCARDIAL INFARCTION, STROKE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jim Parshall M.D.

29c. License number: D40008

29d. Date signed *(Month, Day, Year)*: 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JIM PARSHALL, 9105 FRANKLIN SQUARE DR., BALTIMORE, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0014-510
CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00017

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GIDEON WASHINGTON LANDIS
2. Date of Death Month Day Year: JANUARY 01, 1997
3. Time of Death: 1914PM
4a. Facility Name *(If not institution, give street and number)*: J.H.H. BAYVIEW MEDICAL CENTER E.R.
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 205-05-1815
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 22, 1919
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Fort Howard
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 9238 Todd Avenue
10f. Zip Code: 21052
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever In U.S. Armed Forcas? 1☒Yes 2☐No If Yes, Give Yaar or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Mechanic
16b. Kind of Business/Industry: Automobile Repairs

17. Father's Name *(First, Middle, Last)*: Paul H. Landis
18. Mother's Name *(First, Middle, Maiden Surname)*: Laura E. Crow

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Dorothy M. Landis/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9238 Todd Avenue Fort Howard, Maryland 21052

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest V.A.Cem. Date: 1/06/97
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Johnny L. Jobe
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed? INSPECTION 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Dennis J. Chute M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JANUARY 02, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Submit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna McMahon

2. Date of Death: Month: January; Day: 1; Year: 1997

3. Time of Death: 12:25 am

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-38-6947

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 23, 1906

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7 Barnaby Court

10f. Zip Code: 21093

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: at Home

17. Father's Name (First, Middle, Last): Phillip Schuster

18. Mother's Name (First, Middle, Maiden Surname): Anna Schmitt

19a. Informant's Name/Relationship (Type, Print): Leonard McMahon /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1107 Raven Drive Catonsville, Md 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Parkwood Cemetery

Date: Jan 3 1997

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Robert W. Rowe Jr.

22. Name and Address of Facility: Evans Chapel of Chimes 2325 York Rd. Timonium, Md 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 15504

29d. Date signed (Month, Day, Year): 1-2-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Eddie Nakhuda, M.D, 2300 Dulaney Valley Rd., Towson, Md. 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Estella MONTGOMERY
2. Data of Death (Month, Day, Yaar): January 1, 1997
3. Tima of Deeth: 9:45 am
4a. Facility Nema (If not institution, give straat and number): Franklin Square Hospital Center
4b. City, Town, or Location of Deeth: N/A
4c. County of Death: Baltimore

Funeral Director

5. Social Sacurity Number: 220-24-5037
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 72 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 13, 1924
9. Birthplace (Stata or Foraign Country): NORTH CAROLINA

Usual Rasidanca of Decedant

10a. Stata: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1810 E. 32ND STREET
10f. Zip Coda: 21218
10g. Citizan of What Country?: U.S.A.

11. Maritei Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Dacadent Evar In U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American indian, Black, White, atc. Specify: BLACK

15. Decedant's Education (Specify only highest grada complatad)
Elementary/Secondary (0-12): 12TH
Collega (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): CAFETERIA AIDE
16b. Kind of Businass/Industry: BALTIMORE CITY PUBLIC SCHOOLS

17. Fathar's Nama (First, Middle, Last): LUKE HARDISON
18. Mothar's Nama (First, Middla, Maidan Sumama): THELMA TAFT

19a. Informant's Name/Ralationship (Type, Print): EMANUEL MONTGOMERY - SON
19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Code): 1810 E. 32ND STREET BALTIMORE, MD. 21218

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Piace of Disposition (Nama of camatery, cramatory or other place): MARYLAND NATIONAL MEMORIAL PARK — Date: JANUARY 8, 1997
20c. Location - City or Town, Stata: LAUREL, MARYLAND

21. Signatura of Funaral Sarvica Licansaa: ▶ Calvin B. Scruggs, Sr.
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complicetions that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona causa on each lina.

Approximate interval Between Onsat and Death

Immediate Cause (Finai disaasa or condition resulting in death)
a. Bradycardia to asystoli — 4 Hours

Dua to (or es e consequance of):
b. Cardiac failure

Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disaasa or injury that initieted evants resulting in dath) Last
Dua to (or es a consaquance of):
c. Long standing diabetes millitus

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.
Severe peripheral vascular disease

Congested heart failure, Non Q wave Myocardial infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Piaca of Death (Chack only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Spacify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29e. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladge, deeth occurred at tha time, dete and place, and due to the causa(s) and manner es stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and piace, and due to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ JTAmmons MD
29c. Licansa number: RD01919
29d. Data signed (Month, Day, Year): 1/1/97

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Twanna Ammons M.D. 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Data filad (Month, Day, Year): JAN 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES W NELSON

2. Date of Death Month: JANUARY Dey: 1 Year: 1997

3. Time of Death: 15:20

4a. Facility Name *(If not institution, give street and number)*: University Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-86-5787

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 31 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: November 9, 1965

9. Birthplace *(State or Foreign Country)*: Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1545 Gilmore Street

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: laborer

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Bernard W. Nelson

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Harrison

19a. Informant's Name/Relationship *(Type, Print)*: Mary Horton / Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1147 Calhoun St. Balto., Md. 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion

Date: 1/8/97

20c. Location - City or Town, State: Balto., Md.

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: James A. Morton + Sons 1701 Laurens St. Balto., Md. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — > 1 week

Due to (or as a consequence of):

b. PNEUMONIA — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ACQUIRED IMMUNODEFICIENCY SYNDROME — > 2 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Diabetes.

Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P10239

29d. Date signed *(Month, Day, Year)*: JANUARY 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RICHARD CHUANG, MD; 22 S. GREENE STREET; BALTIMORE MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00021

ITEM:25 G-743 per DR. 1-16-97 eoh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nettie Pinder

2. Date of Death: Month: January Day: 1 Year: 97

3. Time of Death: 1:45 AM

4a. Facility Name (If not institution, give street and number): 608 N. Curley Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 092-26-8899

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1-1-1900

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 608 N. Curley St.

10f. Zip Code: 21205

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeper

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Thomas Henry

18. Mother's Name (First, Middle, Maiden Surname): Sarah Pinder

19a. Informant's Name/Relationship (Type, Print): Sarah Tatum - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 318 Edgewood St. Baltimore, MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Mt. Zion Cemetery

Date: 1/4/97

20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: ▶

22. Name and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Gangrene

Due to (or as a consequence of):

b. Peripheral Vascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Dementia of Alzheimer's Type

Glaucoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patricia Thomas, MD

29c. License number: D35422

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia Thomas, MD. 1830 E. Monument St. Baltimore, MD 21205

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00022

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decadant's Nema (First, Middle, Last): Julia Pittman

2. Deta of Death Month Day Yaar: January 03, 1997

3. Tima of Death: 12 46 AM

4a. Facility Name (If not institution, give street and number): Cherrywood Nursing home 12020 Reistertown Rd.

4b. City, Town, or Location of Daath: Reistetown 21136

4c. County of Death: Baltimore

Funeral Director

5. Social Security Numbar: 243-36-1085

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 77 Yrs.

If Undar 1 Year: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): November 14, 1919

9. Birthplaca (Stata or Foreign Country): North Carolina

Usual Rasidance of Dacadent

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 3550 Corn Stream Road

10f. Zip Code: 21133

10g. Citizan of What Country? USA

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowad 4☒ Divorcad

12. Was Dacadent Ever in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican indian, Black, White, etc. Specify: Black

15. Decadant's Education (Specify only highest grade completed)

Elamantary/Sacondary (0-12): 12

Collaga (1-4or 5+): N/A

16a. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeper

16b. Kind of Businass/Industry: Domestic

17. Father's Nema (First, Middle, Last): J.L. Hamilton

18. Mothar's Name (First, Middle, Maidan Surname): Mary Murphy

19a. Informant's Name/Ralationship (Type, Print): Stephanie Martin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3550 Corn Stream Road Randallstown Md 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Data: January 8, 1997

20c. Location - City or Town, Stata: Baltimore, Md

21. Signatura of Funaral Sarvica Licansaa: Carlton C. Douglass

22. Nama and Addrass of Facility: Douglass Funeral Service 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final diseasa or condition resulting in daath)

e. Interstitial Fibrosis

Due to (or as a consequence of):

b. Systemic Lupus erythematosis

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Dua to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

Diverticulitis

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to compilation of causa of daath? 1☐ Yas 2☐ No

25. Was case rafarrad to medical axaminar? 1☐ Yas 2☒ No

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

28. Placa of Daath (Check only one) Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify)

27. Manner of Daath: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha time, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifier: Julia Pittman

29c. Licansa number: D27123

29d. Data signed (Month, Day, Yaar): 1/3/97

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Judah Minkoff 1750 Reistertown Rd Reistertown, Md 21136

State Registrar

31. Data filed (Month, Day, Yaar): JAN 03 1997

32. Registrar's Signatura

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00023

Physician /Medical Examiner

1. Decadant's Nama *(First, Middla, Last)*: Minnie Elizabeth Straser

2. Data of Deeth — Month: January Dey: 1 Yaar: 1997

3. Tima of Death: 11:50 PM

4a. Facility Name *(If not institution, giva street and number)*: Genesis Nursing Home

4b. City, Town, or Location of Death: Randallstown

4c. County of Daeth: Baltimore

Funeral Director

5. Social Security Number: 213-38-1646

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthdey)*: 91 Yrs. — If Undar 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: November 2, 1905

9. Birthplace *(Stata or Foraign Country)*: Maryland

Usual Rasidanca of Dacedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Numbar: 9109 Liberty Road

10f. Zip Code: 21133

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowad 4☐ Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amaricen Indian, Black, White, etc. *Specify:* White

15. Dacedant's Education *(Spacify only highest grada completed)*: Elamentary/Secondary (0-12) — College (1-4or 5+): 4 Years

16a. Dacedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Laurel Elementary School Prince Georges County

17. Fether's Nama *(First, Middla, Last)*: Harry Storer

18. Mothar's Nama *(First, Middla, Maidan Surname)*: Cora Davis

19a. Informant's Name/Ralationship *(Typa, Print)*: Mrs. Anna Lee Makovitch

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 710 Bayberry Circle Westminster, MD 21157

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Name of cemetary, cramatory or othar place)*: Fort Lincoln Cemetery

Data: 1/3/97

20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signature of Funeral Service Licensee: John Evans

22. Nama and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not antar tha moda of dying, such es cardiac or respiratory errast, shock, or heart failura. List only ona ceusa on aach lina.

Approximate Interval Between Onsat and Death

Immedieta Ceusa (Final diseesa or condition resulting in daath): a. Leukemia — >3 years

Dua to (or as a consequance of):

Saquantially list conditions, if any, laading to immadiate ceusa. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in daath) Last:

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yss 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of ceusa of daath? 1☐ Yes 2☐ No

25. Was cesa rafarred to medical examinar? 1☐ Yas 2☒ No

28. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Othar: 4☒ Nursing Hama 5☐ Rasidance 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, deeth occurred at tha time, date and place, and due to the causa(s) and mannar as statad. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at tha tima, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifiar: Donald Bob MD

29c. License number: D15872

29d. Data signed *(Month, Day, Year)*: January 2 1996

30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print): HAROLD BOB 7220 Park Height 21208

State Registrar

31. Deta filed *(Month, Day, Year)*: JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00024

Physician /Medical Examiner

1. Decadant's Nama *(First, Middle, Last)*: Edith E. Velli

2. Data of Death Month: Jan Day: 1 Yaer: 1997

3. Tima of Death: 5:20 AM

4a. Facility Nama *(If not institution, giva street and number)*: Corien Nursing home

4b. City, Town, or Location of Daath: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-6165

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: Feb 23, 1925

9. Birthpleca *(Stata or Foraign Country)*: MARYLAND

Usuel Rasidanca of Dacedent

10a. Stata: Md

10b. County: N/A

10c. City, Town or Location: BALTIMORE Md.

10d. Inside City Limits: 1☒ Yas 2☐ No

10a. Straet end Number: 711 E. EATON ST.

10f. Zip Coda: 21224

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Navar Married 2☒ Marriad 3☐ Widowad 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* WHITE

15. Decadent's Education *(Spacify only highest greda compleated)*: Elementery/Secondary (0-12): 12 th | Collega (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratired)*: CLERK

16b. Kind of Businass/Industry: SOCIAL SECURITY

17. Fathar's Name *(First, Middla, Last)*: JACOB WHITE

18. Mothar's Name *(First, Middla, Maidan Surnema)*: ANNIE FISHER

19a. Informant's Name/Ralationship *(Typa, Print)*: MARGARET KISKIS

19b. Mailing Address *(Straat end Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 3513 Field Creek Wy Balt. MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatery, cramatory or othar place)*: OAKLAWN Cem. | Data: 1/4/97

20c. Location - City or Town, Stete: BALTIMORE Co. Md.

21. Signature of Funeral Sarvica Licensee: ▶ Jody D. Smith

22. Nama and Address of Facility: HARTLEY MILLER FUNERAL HOME 7527 Harford Rd BALTO Md 21234

Physician /Medical Examiner

23e. Part I. Entar the diseesa, or complications that caused tha daath. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only ona causa on aach lina.

Approximate Interval Between Onset end Deeth

Immadiate Causa (Final disaasa or condition resulting in daath)
e. Respiratory failure — 2 month

Due to (or es a consequense of):
b. emphysema — 10 years

Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated evants resulting in daath) Last
Due to (or as a consaquance of):
c.
Dua to (or es a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings availebla prior to completion of causa of daath? 1☐ Yes 2☐ No

25. Wes casa referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatiant 3☐ DOA | Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, daath occurred at the time, data and place, and due to the causa(s) and mannar as steted. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, dete and piece, and dua to tha cause(s) and mennar stated.

29b. Signature and titla of cartifiar: ▶ Dany Kayhoe MD

29c. Licansa number: 041617

29d. Date signed *(Month, Day, Year)*: Jan 1, 1997

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): Gary Kazlow 10805 Hickory Ridge Rd Columbia Md 21045

State Registrar

31. Data filed *(Month, Dey, Year)*: JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00025

ITEM#8 PER F.H. 1-7-96 FILM#G743 J.A. *Certificate of Death* Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANITA WADE

2. Date of Death Month: JANUARY Day: 2 Year: 1997

3. Time of Death: 10:30 AM

4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-03-9640

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: ~~June~~ MAY 24 1898

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7200 Third Avenue

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: John B. Biemiller

18. Mother's Name *(First, Middle, Maiden Surname)*: Lily E. Kuethe

19a. Informant's Name/Relationship *(Type, Print)*: John W. Wade (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 115 Earl Ave. Roscommon, MI 48653

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Druid Ridge Cemetery

Date: 01/06/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Harry W. Haight

22. Name and Address of Facility: Haight Funeral Home P.O. Box 195 Sykesville MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D44505

29d. Date signed *(Month, Day, Year)*: January 2 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AN IMPRINT — Northwest Hosp Center

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 1997

32. Registrar's Signature: Julia Davidson-Randolph

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00026

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Craig ALLAN Warnick
2. Dete of Deeth Month Dey Yeer: JANUARY 2, 1997
3. Time of Deeth: 10:27 AM
4e. Facility Neme (If not institution, give street end number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE CITY
4c. County of Deeth: City

Funeral Director

5. Social Security Number: 214-64-2965
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Jan. 22,1956
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 16 Ridgelawn Road
10f. Zip Code: 21136
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 6
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Benefit Authorizer
16b. Kind of Business/Industry: Social Security

17. Fether's Neme (First, Middle, Last): Joseph Robert Warnick
18. Mother's Neme (First, Middle, Meiden Surneme): Iris Virginia Hiltner

19e. Informent's Neme/Relationship (Type, Print): Susan Warnick Wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 16 Ridgelawn Rd., Reisterstown, Md. 21136

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Dulaney Valley Mem. Gar. | Dete: Jan 6, 1997 | 20c. Locetion - City or Town, State: Timonium, Md.

21. Signeture of Funerel Service Licensee: H.J. Eckhardt
22. Neme end Address of Fecility: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Finel diseese or condition resulting in deeth)	e. Intraventricular hemorrhage	5 days
Due to (or es e consequenca of):		
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last	b.	
Due to (or es e consequence of):		
	c.	
Due to (or es e consequenca of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D44553
29d. Dete signed (Month, Dey, Yeer): January 2, 1997

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): G-Sung , 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 03 1997
32. Registrar's Signeture: Julia Nordan-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH P. ZAPPACOSTA SR.

2. Date of Death (Month, Day, Year): January 1, 1997

3. Time of Death: 12 Noon

4a. Facility Name (If not institution, give street and number): 3 Eastgate Court

4b. City, Town, or Location of Death: Owings Mills

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-07-8529

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 8, 1919

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 7 Millgate Road

10f. Zip Code: 21117

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 Grade H.S. College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Anchor Freight Co.

17. Father's Name (First, Middle, Last): Tilo Zappacosta

18. Mother's Name (First, Middle, Maiden Surname): Rose Liberto

19a. Informant's Name/Relationship (Type, Print): Mrs. Audelia Zappacosta (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Millgate Road Owings Mills, Md. 21117

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 1/4/97

20c. Location - City or Town, State: Pikesville, Md.

21. Signature of Funeral Service Licensee: Kamb Eline

22. Name and Address of Facility: ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Malignant Astrocytoma

Due to (or as a consequence of):
b. Prostate Cancer

Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mannar as stated. 2 ☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D27123

29d. Data aigned (Month, Day, Year): 1/2/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Judah Minkove 750 Main St Reisterstown Md 21131

State Registrar

31. Date filed (Month, Dey, Year): JAN 03 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0068-510
AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA ARIS

2. Date of Death Month Day Year: JAN. 04, 1997

3. Time of Death: 2102 P

4a. Facility Name (If not Institution, give street and number): 306 E. NORTH AVE.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-40-7469

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 30, 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 306 E. North Avenue

10f. Zip Code: 21202

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Richard Neale Jarboe

18. Mother's Name (First, Middle, Maiden Surname): Theresa Madeline Schustak

19a. Interment's Name/Relationship (Type, Print): Tina M. Kleppinger/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3810 Nicholson St. Hyattsville, MD 20782

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 1/6/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elaine Lake MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): JAN. 05, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: for Davidson Randall

DHMH 16 Rev 6/95

(3)

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00029

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): John Armes

2. Date of Death Month: JAN Day: 1 Year: 97

3. Time of Death: 0106

4a. Facility Neme (If not institution, give street end number): North Arundel Hosp.

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Deeth: AA

Funeral Director

5. Socie! Security Number: 216 76 6743

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. lest birthdey): 31 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Oct. 7, 1965

9. Birthplace (Stete or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Sfreet and Number: 1016 Stoll Place

10f. Zip Code: 21225

10g. Citizen of Whef Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 7 | College (1-4or 5+):

16e. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired): ORDERLY

16b. Kind of Business/Industry: HOSPITAL

17. Father's Neme (First, Middle, Last): John Henry Armes

18. Mother's Name (First, Middle, Maiden Sumeme): Patricia Sue Franks

19e. Informant's Neme/Relationship (Type, Print): Betty J. Vreeland / Sister

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 9013 Woodpark Ct., Baltimore, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Green Mount Crematory

Date: 1-6-97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann

22. Name end Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr.; Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. EXSANGUINATION — Approximate Interval: MINUTES

Due to (or as e consequence of):

b. Vascular Rupture.

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.:

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturei 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: William P. Jones MD Deputy

29c. License number: D06054

29d. Date signed (Month, Dey, Yeer): 1/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William P. Jones, MD. 695 American 21035

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00030

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH MARIE BOHLI

2. Date of Death (Month, Day, Year): January 3, 1997

3. Time of Death: 10:15 AM

4a. Facility Name (If not institution, give street and number): St. Elizabeth Home for Nursing Care

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-04-3122

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 18,1897

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3320 Benson Avenue

10f. Zip Code: 21229

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Hiram Eason

18. Mother's Name (First, Middle, Maiden Surname): Nellie Noonan

19a. Informant's Name/Relationship (Type, Print): Eileen Taylor/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 131 Regester Ave. Baltimore, MD 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gard.

Date: 1/6

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: John O. Mitchell IV

John O. Mitchell, IV

22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Laurence R Gallager, MD

29c. License number: D01786

29d. Date signed (Month, Day, Year): 3 January 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Laurence R. Gallager, M.D. 716 Maiden Choice Lane #101, Catonsville, Maryland 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 0 6 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00031

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNA McCONNELL BRUNGARDT

2. Date of Death (Month, Day, Year): January 2, 1997

3. Time of Death: 8 PM

4a. Facility Name *(If not Institution, give street and number)*: St. Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 513-34-7525

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 18, 1933

9. Birthplace *(State or Foreign Country)*: Kansas

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 205 Belmont Forest Ct. #102

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Baltimore County Schools

17. Father's Name *(First, Middle, Last)*: Willard McConnell

18. Mother's Name *(First, Middle, Maiden Surname)*: Cleo Christesen

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Gilbert Brungardt/husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 205 Belmont Forest Ct. Timonium, Md. 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Fidelis Cemetery

Date: 1/8/97

20c. Location - City or Town, State: Victoria, Kansas

21. Signature of Funeral Service Licensee: Dave D. Ruck

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardio Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Generalized Metastatic Cancer

Due to (or as a consequence of):

c. Cancer of Breast

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. O'Donnell MD

29c. License number: D-09383

29d. Date signed *(Month, Day, Year)*: 1-2-97

30. Name and address of person who completed cause of death (item 23e) (Type, Print): Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Baldwin Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00032

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MARY B. BARTELL

2. Dete of Deeth Month / Dey / Yeer: JANUARY 5, 1997

3. Time of Deeth: 10:15 A.M.

4e. Fecility Neme *(If not institution, give street end number)*: GLEN MEADOWS

4b. City, Town, or Location of Deeth: GLEN ARM

4c. County of Deeth: BALTIMORE

Funeral Director

5. Sociel Security Number: 218-03-6837

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: JAN. 17, 1911

9. Birthplece *(Stete or Foreign Country)*: PENNSYLVANIA

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: GLEN ARM

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 11630 GLEN ARM ROAD

10f. Zip Code: 21057

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12YRS. / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: SUPERVISOR

16b. Kind of Business/Industry: C+P TELEPHONE CO.

17. Father's Neme *(First, Middle, Last)*: DORCY E. SPANGLER

18. Mother's Neme *(First, Middle, Maiden Surneme)*: MILDRED H. SLOTHOWER

19a. Informent's Neme/Relationship *(Type, Print)*: RICHARD A. SPANGLER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9317 MONTEGO AVE. PARKVILLE, MARYLAND 21234

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: DULANEY VALLEY MEMORIAL

Dete: JAN. 8 1997

20c. Location - City or Town, Stete: TIMONIUM, MARYLAND

21. Signeture of Funerel Service Licensee ▶

22. Neme end Address of Fecility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Final diseese or condition resulting in death): e. MULTIPLE INFARCTION DEMENTIA — Years

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)* | 28b. Time of injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 26d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examinar:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier ▶ W. Matthew Riley M.D.

29c. License number: D25205

29d. Dete signed *(Month, Dey, Yeer)*: JANUARY 6, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR. W. A. RILEY 6701 NORTH CHARLES STREET TOWSON, MARYLAND 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 06 1997

32. Registrer's Signeture ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00033

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM BARTLING

2. Date of Death Month Day Year: January 4, 1997

3. Time of Death: Two P.M. 14:00

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-03-3662

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 19, 1910

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1000 E. Joppa Rd. Apt. 401

10f. Zip Code: 21286

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yr's; College (1-4or 5+): 1 yr

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Operating Manager

16b. Kind of Business/Industry: Graybar Electric Co.

17. Father's Name *(First, Middle, Last)*: Edward Bartling

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Virginia R. Getz - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5832 Westchester Hills Ct. Eldersburg, MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: January 7, 1997

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Paul L Hatrick Jr

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Failure	Two Weeks
Due to (or as a consequence of): b.	Empyema	Four Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Diabetes	Ten Years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Walinsky, MD

29c. License number: P1946

29d. Date signed *(Month, Day, Year)*: January 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Walinsky Sinai Hospital of Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00034

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): THOMAS W. BUTLER
2. Dete of Death: Month JAN Dey 4 Yeer 1997
3. Time of Death: 5:03 pm
4e. Facility Neme (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 215-14-4300
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): DEC. 4, 1924
9. Birthplece (Stete or Foreign Country): MARYLAND

Usuel Residence of Decedent

10e. Steta: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street end Number: 21 SOUTH CALVERTON ROAD
10f. Zip Code: 21223
10g. Citizan of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 6TH GRADE; Collega (1-4or 5+):
16e. Decadant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): MOVING & HAULING
16b. Kind of Business/Industry: SELF-EMPLOYED

17. Fether's Neme (First, Middle, Lest): MALACHI BUTLER
18. Mother's Name (First, Middle, Meiden Surneme): FLORENCE ANDERSON

19e. Informent's Neme/Reletionship (Type, Print): FLORINE BUTLER (WIFE)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 21 S. CALVERTON RD., BALTIMORE, MD. 21223

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other pleca): MD. NATIONAL CEMETERY
Dete: 1-9-97
20c. Location - City or Town, Stete: LAUREL, MARYLAND

21. Signeture of Funeral Service Licensee: [signature]
22. Neme end Address of Feciliti: JOSEPH BROWN FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTO. MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the daeth. Do not anter the moda of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line. — Approximate Intarval Between Onset end Deeth

Immedieta Ceuse (Finel disease or condition resulting in deeth)
e. RESPIRATORY ARREST

Due to (or as a consequance of):
b. SEPSIS

Sequentially list conditions, if eny, leeding to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c. INFECTED A-V FISTULA

Due to (or es e consequence of):
d. DIABETIC NEPHROSCLEROSIS

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
KIDNEY FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Ware autopsy findings avelleble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Pleca of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: CURTIS EDAVIS MD
29c. License number: D-21420
29d. Date signed (Month, Dey, Yeer): 5 JAN 97

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): CURTIS EDAVIS MD BON SECOURS HOSP BALTIMORE MD 21223

State Registrar

31. Data filed (Month, Dey, Yeer): JAN 06 1997
32. Registrer's Signeture: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL E. BAIER
2. Date of Death (Month, Day, Year): Jan 2nd 97
3. Time of Death: 8-12PM
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-18-6078
8. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 8 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Grace Land Park
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No X
10e. Street and Number: 1519 Delvale Avenue
10f. Zip Code: 21222
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1941
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cable Reeler
18b. Kind of Business/Industry: Telephone Equipment
17. Father's Name (First, Middle, Last): John Baier
18. Mother's Name (First, Middle, Maiden Surname): Margaret Knorr
19a. Informant's Name/Relationship (Type, Print): Paul E. Baier Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1912 Snyder Ave. Balto., MD. 21222
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Mary
Date: Jan.6
20c. Location - City or Town, State: Dundalk, Maryland
21. Signature of Funeral Service Licensee: Mark A. Chojnacki
22. Name and Address of Facility: W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Baltimore, Md. 21224

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of Pancreas with metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Y.K Shetty MD
29c. License number: D16402
29d. Date signed (Month, Day, Year): Jan, 2nd 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Y.K. SHETTY CHURCH HOSPITAL, BALT, MD 21231

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00036

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLIS BURTON
2. Date of Death: Month Jan Day 2 Year 1997
3. Time of Death: 6:02 AM
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-18-8748
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 12, 1917
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTO
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1512 N. WOLFE ST
10f. Zip Code: 21213
10g. Citizen of What Country?: u.s.a.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NIGHT WATCHMAN
16b. Kind of Business/Industry: BALTO CITY WORKER

17. Father's Name (First, Middle, Last): ALDOLPHUS BURTON
18. Mother's Name (First, Middle, Maiden Surname): CLARA JACKSON

19a. Informant's Name/Relationship (Type, Print): NEALETTE JONES
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 728 RICHWOOD AVE BALTO, MD 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE CEM Date: JAN 9 1997
20c. Location - City or Town, State: BALTO, MD

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	acute myocardial infarction	3 weeks
Due to (or as a consequence of):	coronary artery disease	15 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: prostate cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: B39102
29d. Date signed (Month, Day, Year): Jan 2 1997
30. Name and address of person who completed cause of death (item 23a) (Type, Print): SHU-WN YANG MD Church Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To be Completed by Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00037

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lora Williams Baldwin

2. Date of Death: Month Jan. Day 3 Year 1997

3. Time of Death: 11:05 am.

4a. Facility Name *(If not institution, give street and number)*: Carroll Co. Gen. Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-16-1180

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 6, 1897

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3129 Westminster Street

10f. Zip Code: 21102

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Riveter

16b. Kind of Business/Industry: Manufacturing Co. Glen L. Martin

17. Father's Name *(First, Middle, Last)*: Thomas Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Locke Witten

19a. Informant's Name/Relationship *(Type, Print)*: Cleaborn Houser

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4803 Band Hall Hill Rd. Westminster, Md. 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Davids Cemetery | Date: Jan. 6, 1997

20c. Location - City or Town, State: Hanover, PA.

21. Signature of Funeral Service Licensee: ▶ J. Garth Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure — 3 yrs
Due to (or as a consequence of):
b. Pneumonia — 1 hr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John Middleton

29c. License number: D25443

29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 22a) (Type, Print): John Middleton 688 Poole Rd Westminster, Md 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00038

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel Balsamo

2. Date of Death: Month 1 Day 3 Year 97

3. Time of Death: 6:29am

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Geriatrics Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-9170

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 2, 1920

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Balto.

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3138 Yorkway

10f. Zip Code: 21222

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8yrs.

College (1-4or 5+): n.a.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Trucker

17. Father's Name (First, Middle, Last): Salvatore Balsamo

18. Mother's Name (First, Middle, Maiden Surname): Josephine Cappa

19a. Informant's Name/Relationship (Type, Print): Mark Balsamo/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 93 Yew Rd. Baltimore Md. 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery

Date: 1-6-97

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: 7110 Sollers Point Rd. Balto. Md. 21222 CONNELLY FUNERAL HOME OF DUNDALK

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Malnutrition

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Diabetes

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Fracture of Right Clavicle, Anemia, Coronary Artery Disease, Pressure Decubitus Ulcer, Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Colleen Christmas

29c. License number: D0051185

29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Colleen Christmas, MD, Hopkins Geriatrics Center, 5505 Hopkins Bayview Circle, Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ITEMS: 32. PER FIELD REP. **Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

FILM G-743 1/6/97 t.t

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS PAUL COLGAN

2. Date of Death: Month: January; Day: 1; Year: 1997

3. Time of Death: 6:30A

4a. Facility Name (If not institution, give street and number): 4916 Walther Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-05-9273

6. Sex: XM 2 F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 29, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 XYes 2 No

10e. Street and Number: 4916 Walther Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: USA

11. Marital Status: X1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Currier

16b. Kind of Business/Industry: Delivery

17. Father's Name (First, Middle, Last): John Charles Colgan

18. Mother's Name (First, Middle, Maiden Surname): Ann Jane Rahll

19a. Informant's Name/Relationship (Type, Print): Sr. Janice Colgan SSND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6401 North Charles Street Baltimore Maryland 21212

20a. Method of Disposition: 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Date: 1/3/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Hyden Kenaka

22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dilated Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease — 10 yrs

Due to (or as a consequence of):

c. unknown cardiomyopathy

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes X2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Henry Meilman MD

29c. License number: D32106

29d. Date signed (Month, Day, Year): 01/02/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HENRY MEILMAN, MD 200 E 33rd ST Suite 631 Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Julia Dowling Rabat

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00040

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: RUTH JACKSON CONWAY

2. Dete of Deeth — Month: JANUARY Day: 03 Yeer: 97

3. Time of Deeth: 7:40 P.M.

4e. Facility Neme *(If not institution, give street end number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Deeth: TOWSON, MARYLAND

4c. County of Deeth: BALTIMORE

Funeral Director

5. Sociel Security Number: 217 26 7352

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. iest birthday)*: 84 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Nov. 11, 1911

9. Birthpiece *(Stete or Foreign Country)*: MARYLAND

Usuei Residence of Decedent

10a. Stete: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 231 BURKE AVE APT B

10f. Zip Code: 21204

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12YRS. College (1-4or 5+):

16e. Decedent's Usuei Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: SHIPPING CLERK

16b. Kind of Business/Industry: MURRAY CORPORATION

17. Fether's Neme *(First, Middle, Last)*: HOWARD JACKSON

18. Mother's Neme *(First, Middle, Meiden Surneme)*: MABRY CARROLL

19e. Informent's Name/Reletionship *(Type, Print)*: OLIVER V. CONWAY

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 231 BURKE AVE APT B TOWSON, MARYLAND 21204

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removei from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: EVANS FUNERAL CHAPEL — BEL AIR, MD.

Dete: JAN. 6 1997

20c. Locetion - City or Town, Stete: FOREST HILL, MARYLAND

21. Signeture of Funerel Service Licensee: [signature]

22. Neme end Address of Feciility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

Physician /Medical Examiner

23e. Pert 1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finei diseese or condition resulting in death): e. CEREBRO VASCULAR ACCIDENT — 1 DAY

Due to (or es a consequence of):

Sequentieily list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert i.: HYPERTENSION; DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably X☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitei: 1☒ inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of injury *(Month, Dey Yeer)*

28b. Time of injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete and pieca, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: [signature] John P Mehta MD

29c. License number: D41410

29d. Dete signed *(Month, Dey, Yeer)*: January 04, 1997

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print): JOGINDER MEHTA M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 06 1997

32. Registrer's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 000041

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOIS JEANNETTE CROUSE
2. Date of Death (Month, Day, Year): JANUARY 1, 1997
3. Time of Death: 3:05 AM
4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON, MARYLAND
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-28-8558
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 23, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 114 E. Timonium Road
10f. Zip Code: 21093
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): James P. Layfield
18. Mother's Name (First, Middle, Maiden Surname): A. Maria Beard

19a. Informant's Name/Relationship (Type, Print): Donald E. Crouse Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 E. Timonium Road Timonium, Maryland 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corporation — Date: 1/3/97
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Donald E. Crouse
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LARGE CELL METASTATIC LUNG CARCINOMA DISEASE — 1994

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 1996

Due to (or as a consequence of):
d. INFERIOR MYOCARDIAC INFARCTION — 4/22/96

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST LEFT UPPER LOBECTOMY

PARTIAL LEFT MASTOIDECTOMY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ceballos MD
29c. License number: D25886
29d. Date signed (Month, Day, Year): 1.1.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LILIA CEBALLOS, M.D., 7505 OSLER DRIVE, S-501 TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00042

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace Driscoll

2. Date of Death Month Day Year: January 2, 1997

3. Time of Death: 12:03 PM

4a. Facility Name *(If not Institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 030-03-1625

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 27, 1918

9. Birthplace *(State or Foreign Country)*: Massachustts

Usuei Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore , City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6401 Loch Raven Blvd.

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Michael J. Harkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Krupp

19a. informent's Name/Relationship *(Type, Print)*: William M. Driscoll / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6414 Brook Ave. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piace of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery | Date: 1/6/97

20c. Location - City or Town, Steta: Baltimore , Maryland

21. Signature of Funeral Service Licensee: Ronald C. Shafer Jr.

22. Name and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopay performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Couid not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Lydia R. Best, MD

29c. License number: AT2438946

29d. Date signed *(Month, Day, Year)*: January 2 - 1997

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Lydia R. Best Union Memorial Hospital Baltimore, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Item 1 1-13-97 FilmG743 W.H.Per F/H

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00043

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilmer B. Dodson
2. Date of Death Month Day Year: January 3, 1997
3. Time of Death: 5:00 a.m.
4a. Facility Name *(If not institution, give street and number)*: 4100 Loch Raven Blvd.
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-20-5474
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 18, 1925
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4100 Loch Raven Blvd.
10f. Zip Code: 21218
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 7
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Corporate Attorney
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Henry T. Dodson
18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia A. Wilmor

19a. Informant's Name/Relationship *(Type, Print)*: Janie ~~Jamie~~ E. Dodson (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4100 Loch Raven Blvd Baltimore, Md. 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial — Date: 1/6/97
20c. Location - City or Town, State: Dorsey, Maryland

21. Signature of Funeral Service Licensee: Milton J Knight Jr — Milton J. Knight Jr
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Retroperitoneal Colon Ca	16 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Purtell Staff physician
29c. License number: D19714
29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL PURTELL JHBMC 4940 EASTERN AVE, BALTIMORE MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-0043-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES T. DAVIS
2. Date of Death (Month, Day, Year): JAN. 3, 1997
3. Time of Death: 0300 AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL S.T.U
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-60-9806
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 10 1952
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1341 MOSHER STREET
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: City Of Baltimore

17. Father's Name (First, Middle, Last): Otha L. Davis
18. Mother's Name (First, Middle, Maiden Surname): Fannie Fair

19a. Informant's Name/Relationship (Type, Print): Fannie M. Davis/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1341 Mosher Street, Baltimore, Maryland 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park
Date: 1-8-97
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles H. Burrell
22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GUNSHOT WOUND OF HEAD	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☑ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 1-2-97
28b. Time of Injury: 2321B M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: SUBJECT WAS SHOT.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2400 ETTING ST. BALTIMORE MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Bowden
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYDORIS D. KOROW M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00045

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Evan Hayes Doom

2. Data of Death — Month: January; Day: 1; Year: 1997

3. Time of Death: 6:40pm

4a. Facility Name *(If not institution, give street and number)*: 317 Homberg Avenue

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 400-32-6251

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 12, 1926

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residance of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 83 Weber Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bus Driver

16b. Kind of Business/Industry: Public Transportation

17. Father's Name *(First, Middle, Last)*: Frank H. Doom

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Sherbut

19a. Informant's Name/Relationship *(Type, Print)*: Barbara A. Neal (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 317 Homberg Avenue Essex, Md. 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens — Date: 1/4/1997

20c. Location - City or Town, State: Baltimore Co. ,Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex,Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	BRAIN METASTASES	6 MOS.
Due to (or as a consequance of):		
b.	CARCINOMA OF LUNG	4 YRS.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequance of): c.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	10 YRS.
Due to (or as a consequance of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Heart Disease with Old Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residance 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 17728

29d. Date signed *(Month, Day, Year)*: January 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ba Yin Oung M.D. P.A. 8022 Belair Road Baltimore ,Md. 21236

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997 — Local Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE NIGHTINGALE ENRIGHT

2. Date of Death Month Dey Yeer: January 1, 1997

3. Time of Death: 5:33 P.M.

4a. Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-32-9912

6. Sex: 1☐ M 2☒ F (X)

7. Age (In yrs. last birthdey) Yrs.: 86

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 13, 1910

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No (XXX)

10e. Street end Number: 1007 Woodson Road

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☐ Married (XXX) Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes (XXX) No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes (XXX) No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Occupational Therapist

16b. Kind of Business/Industry: Hospital

17. Fether's Neme (First, Middle, Last): John Michael Potter

18. Mother's Neme (First, Middle, Meiden Surneme): Edith Nora Williams

19e. Informant's Neme/Reletionship (Type, Print): Mary Kathleen Palmisano DTR

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6608 Loch Raven Blvd. Baltimore, Maryland 21239

20a. Method of Disposition: 1☐ Buriel 2(XXX) emetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Dete: 1/3/96

20c. Location - City or Town, State: Baltimore Maryland

21. Signeture of Funerel Service Licensee: Dennis Stephen Kenakes

22. Neme end Address of Feciility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Pert1. Enter the diseese or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immedlete Cause (Finel diseese or condition resulting in deeth)

e. MALIGNANT PLEURAL EFFUSIONS — 6 mos.

Due to (or es a consequence of):

b. LUNG CANCER — 2yrs.

Sequentially list conditions, if eny, leeding to immedlete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evailable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)

Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Locetion (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and manner as stated. 2☐ Medicel Exeminer: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Kendall R Faulkner

29c. License number: D25643

29d. Dete signed (Month, Day, Year): 1/2/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

State Registrar

31. Dete filed (Month, Day, Year): JAN 06 1997

32. Registrer's Signeture: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00047

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: John J. Folderauer
2. Data of Death Month Day Year: January 1, 1997
3. Time of Death: 7:10 P.M.
4a. Facility Name *(If not institution, give street and number)*: 609 Old Stage Road
4b. City, Town, or Location of Daeth: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Numbar: 217-05-5377
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)* Yrs.: 77
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: June 17, 1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usuei Residence of Dacedant

10e. Stata: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 609 Old State Road
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indien, Black, Whita, atc. *Specify:* White

15. Dacedant's Education *(Specify only highest grada completed)*: Elementery/Secondary (0-12): 10 / Collaga (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Rigger
16b. Kind of Businass/Industry: Coast Guard

17. Fether's Neme *(First, Middla, Last)*: Godfrey Folderauer
18. Mothar's Nama *(First, Middla, Maiden Surname)*: Grace Jones

19a. Informant's Name/Ralationship *(Type, Print)*: Gloria Vovak/Companion
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 609 Old Stage Rd. Glen Burnie, MD 21061

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Nama of cemetary, cramatory or othar place)*: Crownsville MD Vet. Cem.
Data: Jan. 6,1997
20c. Location - City or Town, Stata: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not anter the moda of dying, such as cardiac or raspiratory arrest, shock, or heert failura. List only ona cause on aach lina. — Approximate Intarval Between Onset and Deeth

Immedieta Causa (Finai disaasa or condition rasulting in daeth)
a. Basal Cell Carcinoma of Skull Base
Due to (or as a consequence of):
Brain.

Sequentlaily list conditions, if eny, laading to immadiata cause. Enter Underlying Causa (Diseasa or injury thet initiated avants rasulting in deeth) Last
b.
Due to (or as a consequanca of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at the time, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: [signature]
29c. Licensa number: D3078(
29d. Data signed *(Month, Day, Year)*: Janauary 3, 1996

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print): Dr. Douglas Mattox 419 W. Redwood Street Baltimore, MD 21201 Suite 360

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 0 6 1997
32. Registrer's Signatura: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THELMA C. GOTTLEIB
2. Data of Death Month JANUARY Day 5, Year 1997
3. Time of Death 12 40 PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-12-2401
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): September 16
9. Birthplace (State or Foreign Country): 1922 VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: PASADENA
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 962 DUVALL HWY.
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOUSEHOLD

17. Father's Name (First, Middle, Last): HENRY BURKE
18. Mother's Name (First, Middle, Maiden Surname): ANNIE IMMLER

19a. Informant's Name/Relationship (Type, Print): CHARLES L. GOTTLEIB - HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 962 DUVALL HWY. PASADENA, MARYLAND 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): GLEN HAVEN CEMETERY
Data: JAN. 8, 97
20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Hilary L. Stallings Jr.
22. Name and Address of Facility: STALLINGS FUNERAL HOME P.A. 3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEPTIC SHOCK
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. SEPSIS
Due to (or as a consequence of):
c. URINARY TRACT INFECTION
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Johnson Boateng MD
29c. License number: D47861
29d. Date signed (Month, Day, Year): JANUARY 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH BOATENG MD NORTH ARUNDEL HOSP. GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00049

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CORY GENTRY

2. Date of Death Month Day Year: January 2, 1997

3. Time of Death: 10:15 a.m.

4a. Facility Name *(If not institution, give street and number)*: VA MEDICAL CENTER

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death: BALTIMORE COUNTY

Funeral Director

5. Social Security Number: 414-42-7990

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 20, 1931

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedant

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 138 N. Streeper St.

10f. Zip Code: 21224

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: 1948-54

13. Wes Decedent of Hispanic Origin? (Specify Yaa or No- If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Route Salesman

16b. Kind of Business/Industry: Beverage Company

17. Father's Neme *(First, Middle, Last)*: Bartley Gentry

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Roxie Tweed

19a. Informent's Neme/Reletionship *(Type, Print)*: Dolores J. Gentry / wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Steta, Zip Code)*: 138 N. Streeper St., Baltimore, MD 21224

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Ramovel from Stete 4 [ ] Donetion 5 [ ] Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Green Mount Crematory

Dete: 1/4/97

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann

22. Neme end Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21226

Physician /Medical Examiner

23a. Part1. Enter the disaese, or complications thet caused the deeth. Do not enter tha mode of dying, such es cardiec or respiretory errest, shock, or haart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finei diseese or condition resulting in deeth)

e. CONGESTIVE HEART FAILURE

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest

b. ADULT RESPIRATORY DISTRESS SYNDROME

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation, Hypertension, Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case refarred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death *(Check only one)*: Hoapital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residance 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, etreet, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner ea ateted. 2 [ ] **Medical Examiner**: On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to tha cause(s) and menner steted.

29b. Signature and title of certifier: ChandrakalaRaja

29c. Licanse number: D45244

29d. Dete signed *(Month, Dey, Year)*: 1-2-97

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): CHANDRAKALA RAJA, M.D., VA MEDICAL CENTER, FORT HOWARD, MD 21052

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 06 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital's Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial-transit

471

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William, H, Geatty
2. Date of Death: Month 1 Day 4 Year 97
3. Time of Death: 10 22 AM
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-05-9209
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 28, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1628 Bolton Street
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12):
College (1-4or 5+): 2
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Naval Inspector
16b. Kind of Business/Industry: Government Employee

17. Father's Nama (First, Middle, Last): Jonas Geatty
18. Mother's Name (First, Middle, Maiden Surname): Elsie R. Eckard

19a. Informent's Name/Relationship (Type, Print): Elizabeth Geatty (Wife)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 1628 Bolton Street, Baltimore, Maryland 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crametory or other place): Lorraine Park Cemetery
Data: 1/8/97
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: A. Alan Seitz, Jr.
22. Name and Address of Facility: A. Alan Seitz, Jr. Funeral Home, 3818 Roland Avenue, Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death)
a. Atherosclerotic Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequance of):
c.

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No
26. Piece of Death (Check only one) Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturai 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and menner stated.

29b. Signatura and title of certifier
29c. License number: P10221
29d. Data signed (Month, Day, Year): 1/4/97

30. Neme and address of person who completed cause of death (item 23a) (Type, Print): JAMES WANG University of Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Gisela Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00051

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCES W. HILLEARY
2. Date of Death Month / Day / Year: JANUARY 1 1997
3. Time of Death: 07:34
4a. Facility Name *(If not institution, give street and number)*: Shock Trauma Ctr., Univ. of MD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-38-9535
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAR 13, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 416 Heron Point
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Henry E. Wright
18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Earle

19a. Informant's Name/Relationship *(Type, Print)*: Henry M. Hilleary/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 215 Waltham Farm Ln. Centreville, MD 21617

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. — Date: 1/3/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Sepsis	5 DAYS
Due to (or as a consequence of): b.	Closed Head Injury	7 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Motor Vehicle Accident	7 DAYS
d.		

A type M autopsy was performed by the Chief Medical Examiner's Office

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 12-25-96
28b. Time of Injury: 1444 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Motor Vehicle Accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Roadway
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Rubin Clark Road, Queen Anne's Co. Centreville, Md

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Clifford E. Boehm
29c. License number: D37884
29d. Date signed *(Month, Day, Year)*: 1-1-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Clifford E. Boehm, M.D. Shock Trauma Ctr.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roseanne O. Hodgdon

2. Date of Death — Month: January Day: 1 Year: 1997

3. Time of Death: 7:05 PM

4a. Facility Name (If not institution, give street and number): Gilcrest Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-20-1445

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): OCT. 17 1926

9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: LUTHERVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 23 ATHERTON ROAD

10f. Zip Code: 21093

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 YRS.

College (1-4or 5+): 6 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ART TEACHER

16b. Kind of Business/Industry: BALTIMORE COUNTY

17. Father's Name (First, Middle, Last): JOSEPH OCKER

18. Mother's Name (First, Middle, Maiden Surname): SARAH RUTH ALLEN

19a. Informant's Name/Relationship (Type, Print): JOANNE S. TOMKO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234: 4046 FOREST VALLEY ROAD PARKVILLE, MARYLAND

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL — BEL AIR, P.A.

Date: JAN. 3 1997

20c. Location - City or Town, State: FOREST HILL, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 21050, 3 NEWPORT DRIVE FOREST HILL, MARYLAND

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Lung Cancer — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): NA

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): January 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley, MD GBMC 6701 N. Charles St. Balto. md 21204

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SUSAN C. HEATH
2. Date of Death (Month, Day, Year): JAN 2, 1997
3. Time of Death: 7 10 PM
4e. Facility Name (If not institution, give street and number): UNIVERSITY of MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 218-72-7558
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 26, 1958
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: CARNEY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10110 FERGUSON Rd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNT MANAGER
16b. Kind of Business/Industry: Willis Corroon Corp.
17. Father's Name (First, Middle, Last): ROBERT J. HEATH
18. Mother's Name (First, Middle, Maiden Surname): BETTY ROBERTS
19a. Informant's Name/Relationship (Type, Print): BETTY R. HEATH
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10110 FURGUSON
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BEL AIR MEMORIAL Gdns
Date: JAN 7 1997
20c. Location - City or Town, State: BEL AIR Md.
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EVANS Chapel of Memories 8800 Harford Rd

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 5 days
Due to (or as a consequence of):
b. Dilated Cardiomyopathy — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scot Haber MD
29c. License number: P09738
29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haber MD 22 S Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00054

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ANNA E. HAJEK

2. Date of Death (Month, Dey, Yeer): JANUARY 2, 1997

3. Time of Deeth: 5:05 A.M.

4a. Facility Neme (If not institution, give street end number): PIKESVILLE NURSING + CONVALESANT HOME

4b. City, Town, or Location of Deeth: PIKESVILLE

4c. County of Deeth: BALTIMORE

Funeral Director

5. Sociel Security Number: 215-58-4340

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 89 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Deate of Birth (Month, Dey, Yeer): JUNE 25, 1907

9. Birthplace (Stete or Foreign Country): MARYLAND

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3104 TEXAS AVE.

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 YRS. College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use retired): AT HOME

16b. Kind of Business/Industry: HOUSEWIFE

17. Fether's Neme (First, Middle, Last): THOMAS BARRETT

18. Mother's Neme (First, Middle, Maiden Surneme): MINNIE WILDHAM

19e. Informent's Name/Reletionship (Type, Print): VIRGINIA ESPY

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11722 MORNING MIST LANE COLUMBIA, MARYLAND 21044

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): BOHEMIAN NAT. CEMETERY

Dete: JAN. 4TH 1997

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signeture of Funerel Service Licensee:

22. Neme end Address of Fecility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Cerebral Thrombosis — 2 weeks

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last:

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicai exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office buiiding, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, death occurred et the time, date and piece, end due to the ceuse(s) end manner steted.

29b. Signeture end Title of certifier:

29c. License number: D15872

29d. Dete signed (Month, Dey, Yeer): JANUARY 3, 1997

30. Neme end address of person who compieted cause of death (Item 23a) (Type, Print): DR. HAROLD BOB 7220 PARK HEIGHTS AVE. BALTIMORE, MARYLAND 21208

State Registrar

31. Dete filed (Month, Day, Yeer): JAN 06 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NORA H HARRIS
2. Date of Death Month Day Year: JANUARY - 5 - 1997
3. Time of Death: 4 44 AM
4a. Facility Name (If not institution, give street and number): GILCHREST Hospice Center
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 491-26-0679
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 25, 1927
9. Birthplace (State or Foreign Country): MISSOURI

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8718 BAKER AVE
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): William THOMAS HEADRICK
18. Mother's Name (First, Middle, Maiden Surname): OLLIE APRIL BENTON

19a. Informant's Name/Relationship (Type, Print): BARBARA PREECE / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3317 HISS AVE BALTO. MD. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS of FAITH
Date: JAN 8 1997
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Robert L. Reardy
22. Name and Address of Facility: EVANS CHAPEL of MEMORIES 8800 HARFORD Rd.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. widely metastatic Breast Cancer	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): NA
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 5, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Patricia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melissa Heydenreich

2. Date of Death: Month: January Day: 1 Year: 1997

3. Time of Death: 1143PM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 162-46-5086

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 31 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 14 1965

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: VIRGINIA

10b. County:

10c. City, Town or Location: ALEXANDRIA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 414 EAST ALEXANDRIA STREET

10f. Zip Code: 22301

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): +5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ATTORNEY

16b. Kind of Business/Industry: GOVERNMENT (FTC)

17. Father's Name (First, Middle, Last): ROBERT A. HEYDENREICH

18. Mother's Name (First, Middle, Maiden Surname): SUSAN MINNICH

19a. Informant's Name/Relationship (Type, Print): JOHN DUNCAN MARPLE - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 414 E. ALEXANDRIA ST. ALEXANDRIA VIRGINIA 22301

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PINE HALL CEMETERY

Date: JAN.5,97

20c. Location - City or Town, State: STATE COLLEGE, PA.

21. Signature of Funeral Service Licensee: Hilary Lee Stallings Jr.

22. Name and Address of Facility: Stallings Funeral Home PA
3111 Mountain Rd., Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Septic shock — 24 hrs

Due to (or as a consequence of):
b. pneumonia — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D23887

29d. Date signed (Month, Day, Year): January 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard F Ambinder, Johns Hopkins Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00057

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CALLIE HITE
2. Data of Daath Month: JANUARY Day: 4 Year: 1997
3. Time of Death: 540AM
4a. Facility Nama *(If not institution, giva street and number)*: North West Hospital Center
4b. City, Town, or Location of Daath: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 224-24-9153
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthdey)*: 81 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sept. 24, 1915
9. Birthplaca *(Stata or Foraign Country)*: Virginia

Usual Rasidanca of Dacadent

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lochearn
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 6825 Campfield Road
10f. Zip Coda: 21207
10g. Citizen of What Country?: United States

11. Maritel Statua: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade compleated)*: Elamentery/Secondery (0-12): 6; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Lineworker
16b. Kind of Businass/Industry: Calvert Distilleries

17. Fethar's Nama *(First, Middle, Last)*: Walter Hite
18. Mothar's Nama *(First, Middle, Maiden Sumame)*: Mary Lunsford

19a. Informent's Neme/Ralationship *(Type, Print)*: Shirley Leeman/Friend
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1819 Norfolk Rd. Glen Burnie, MD 21061

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, cremetory or othar piece)*: Mt. Carmel Cem.
Deta: Jan. 8, 1997
20c. Location - City or Town, Steta: Steeles Tavern, Virginia

21. Signature of Funaral Service Licensee: Cori L. Eberly
22. Nama and Addrass of Facility: Kirkley-Ruddick Funeral Home, 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or respiretory arrast, shock, or haart failura. List only ona ceusa on aach lina.

Approximete Intarval Between Onset and Death

Immediata Causa (Finel diseesa or condition resulting in deeth):
a. Pneumonia — Approximate Interval: 6 Days
Dua to (or as a consequance of):
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Dua to (or es a consequence of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.
Atrial Fibrillation
Anemia
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Deta of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledga, daath occurred at the tima, dete and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination end/or invastigation, in my opinion, daath occurred at tha tima, date and piece, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifier: MD
29c. License number: D41505
29d. Dete signed *(Month, Day, Year)*: January 4 1997

30. Name and address of person who completed causa of death (Item 23e) (Type, Print): AJ IMPERIAL J. — NONE.

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: Judy Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

WRC
97-0052-510
ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM g-743 1/14/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNEST DENNIS HOUSE
2. Data of Death Month Dey Year: JAN. 03, 1997
3. Time of Death: 10:40 PM
4a. Facility Name (If not institution, giva street and number): 830 LYNHURST ST.
4b. City, Town, or Location of Daath: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Numbar: 217-70-1940
6. Sex: 1☒M 2☐F
7. Aga (In yrs. last birthday): 38 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Day, Yaar): MArch 20, 1958
9. Birthplace (Stata or Foraign Country): MD

Usual Rasidanca of Decedant

10a. Stata: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yas 2☐No
10e. Street end Number: 830 Lynhurst St.
10f. Zip Coda: 21229
10g. Citizan of What Country?: USA

11. Marital Status: 1☒Never Marriad 2☐Married 3☐Widowed 4☐Divorced
12. Was Decadant Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:
13. Was Decadant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: Black

15. Decadant's Education (Specify only highast grade complatad)
Elamentary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Laborer
16b. Kind of Businass/Industry: Car Wash

17. Fathar's Name (First, Middla, Last): Joel House
18. Mothar's Nama (First, Middla, Maidan Surnama): Ruth McKee

19a. Informant's Name/Ralationship (Type, Print): Ruth House/ mother
19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda): 830 Lynhurst St. Balto., MD 21229

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Othar (Specify)
20b. Placa of Disposition (Name of cematary, cramatory or othar piece): Western Star
Data: 1/9/97
20c. Location - City or Town, Stata: Baltimore, MD

21. Signatura of Funeral Service Licansee: James A Morton
22. Nama and Address of Facility: James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only one causa on each line.

Approximate Intervel Between Onset and Death

Immediata Causa (Finel diseasa or condition resulting in daath): a. NARCOTIC AND COCAINE INTOXICATION

Dua to (or as a consequenca of):

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or Injury thet initiated avents resulting in daath) Last:
b.
Dua to (or es a consequanca of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the causs of death? 1☐Yss 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yas 2☐No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☒Yas 2☐No

25. Was casa raferred to medical examinar? 1☒Yas 2☐No

28. Place of Death (Check only ona)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Homa 5☒Residanca 6☐Othar (Specify)

27. Mannar of Daath: 1☐Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding Invastigation 6☒Could not be datarmined

28a. Data of Injury (Month, Day Yaar): 1-3-97
28b. Tima of Injury: UNKNOWN M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: UNKNOWN

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 830 LYNHURST ST. BALTIMORE, MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifiar (Check only one): 1☐**Certifying Physician:** To tha best of my knowledga, daath occurrad at the tima, data and placa, and dua to tha causa(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: Lauralee Locke MD
29c. License number: O.C.M.E.
29d. Dete signed (Month, Day, Yaar): JAN. 04, 1997

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Yaar): JAN 06 1997
32. Registrar's Signatura: Gisha Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00059

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: GLADYS JEWEL HILL

2. Date of Death Month / Dey / Yeer: JANUARY 3 1997

3. Time of Death: 2:45 pm

4e. Facility Name *(If not Institution, give street end number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Sccial Security Number: 212-30-6355

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 09/19/05

9. Birthplece *(Stete or Foreign Country)*: Texas

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 8418 Loch Raven Blvd.

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bieck, White, etc. *Specify:* white

15. Decedent's Edcetion *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 11TH | College (1-4or 5+)

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Stock Supervisor

16b. Kind of Business/Industry: retail store

17. Fether's Neme *(First, Middle, Last)*: Nathan Sammuel Isaacks

18. Mother's Name *(First, Middle, Meiden Surneme)*: Nannie Rich

19a. Informent's Neme/Reletionship *(Type, Print)*: Gladys M. Kent - Daughter

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8418 Loch Raven Blvd.; Towson, MD 21286

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lakeview Memorial Park

Dete: 01/07/97

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Neme end Address of Feciility: Johnson Funeral Home 8521 Loch Raven Blvd.; Towson, MD 21286

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Finel diseese or condition resulting in deeth) e.	acute renal failure	7 days
Due to (or as e consequence of):		
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest b.	chronic renal Failure	2 years
Due to (or es e consequence of):		
c.	diabetes mellitus	20 years
Due to (or as e consequence of):		
d.		

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of deeth?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☑ **Unknown**

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*: N/A

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and mennar es stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MA

29c. License number: D41104

29d. Dete signed *(Month, Dey, Yeer)*: 1.3.97

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Ted Hook MD. 7825 York Rd Towson MD 21204.

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 06 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00060

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOIS HARVEY

2. Data of Deeth — Month: JAN Day: 3 Year: 1997

3. Tima of Death: 5:17 p.m

4a. Facility Nama *(If not institution, giva street and number)*: Good Samaritan Hospital

4b. City, Town, or Locallon of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-16-6924

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthdey)*: 72 Yrs.

If Under 1 Yeer — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Deta of Birth *(Month, Day, Year)*: Aug 23, 1924

9. Birthpiaca *(Stata or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. Stata: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4009 Duvall Avenue

10f. Zip Coda: 21216

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Year or Detes:

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amarican Indian, Black, Whita, etc. *Specify:* BLACK

15. Decedant's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): Collega (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Teacher

16b. Kind of Business/Industry: Balto City-Dept of Ed.

17. Fathar's Nama *(First, Middle, Last)*: David A. Lansdowne

18. Mothar's Nama *(First, Middle, Meiden Surname)*: Lucy Myrie

19a. Informant's Name/Ratationship *(Type, Print)*: Charles Lansdowne brother

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 514 North Arlington Avenue Baltimore, MD 21223

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, crematory or othar place)*: Arbutus Memorial Park

Data: Jan 8th

20c. Location - City or Town, Stata: Baltimore County, MD

21. Signature of Funeral Sarvice Licensee: ▶ Herbert E Nutter

22. Nema end Addrass of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Finai disaasa or condition rasulting in deeth)

a. RUPTURE of AORTIC ANNEURYSIM — 5 minutes

Dua to (or as a consequance of):

b. Peripheral Vascular Disease — Years

Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last

Dua to (or as a consequance of):

c. End Stage Renal Disease — Yeas

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabia prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Was casa refarred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Deeth *(Check only ona)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar stated.

29b. Signatura end title of certifier: ▶ MD.

29c. License number: P01853

29d. Deta signed *(Month, Day, Year)*: Jan 13 1997

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): JACQUES KPODUNU GOOD SAMARITAN HOSPITAL

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours aftar death.

To the Funeral Director: Aftar this certificata has been signed by the attending physician and completaly filled in by tha funaral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY Alice Holt
2. Date of Death Month Day Year: JANUARY 03-1997
3. Time of Death: 4:20 AM
4a. Facility Name (If not institution, give street and number): Sandtown Winchester Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: none

Funeral Director

5. Social Security Number: 216-24-0272
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 27, 1916
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Maryland
10b. County: none
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 410 Argyle Ave.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Afro American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+): none
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: own Home

17. Father's Name (First, Middle, Last): Thomas Butler
18. Mother's Name (First, Middle, Maiden Surname): Mary Johnson Butler

19a. Informant's Name/Relationship (Type, Print): Terry Holt (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 410 Argyle Ave Baltimore, Md 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Mount Zion
Date: 1/4/97
20c. Location - City or Town, State: Lansdowne, Maryland

21. Signature of Funeral Service Licensee: Nancy M. Cullasee
22. Name and Address of Facility: Wallace Funeral Service, 3405 W. Franklin St, Baltimore, Maryland 21229

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Severe Atherosclerotic Cardiovascular disease	10 Yr+
Due to (or as a consequence of): b.	Myocardial Infarction	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	cerebrovascular disease	4 Yr+
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1☐ Yes 2☐ No N/A
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mien-D Koung, MD
29c. License number: D31865
29d. Date signed (Month, Day, Year): 1/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mien-D Koung, Sandtown Winchester Home

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00062

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: John Peirpoint Jackson

2. Deta of Deeth: Month January Dey 02 Yeer 1997

3. Time of Death: 2025

4a. Facility Neme *(If not institution, giva street end number)*: Union Memorial Hospital

4b. City, Town, or Location of Deeth: Baltimore City

4c. County of Deeth: n/a

Funeral Director

5. Social Security Number: 409-16-0647

6. Sex: XX 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 82 Yrs. If Under 1 Yaar: Months / Deys. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: MAR. 28, 1914

9. Birthplece *(Stete or Foreign Country)*: FLORIDA

Usuel Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes XX 2☐ No

10e. Street and Number: 1104 COURTNEY ROAD

10f. Zip Code: 21227

10g. Citizen of Whet Country?: UNITED STATES

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☐ XXorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yes 2☐ No. If Yes, Give Yeer or Detas: wwii

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 10 th. College (1-4or 5+): -

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MARYLAND DRYDOCK

16b. Kind of Business/Industry: SHIPPING CO.

17. Father's Nema *(First, Middle, Last)*: JOHN WESLEY JACKSON

18. Mother's Neme *(First, Middle, Meidan Sumeme)*: MARGARITE FORD

19a. Informent's Neme/Reletionship *(Type, Print)*: DEBRA GAITHER

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1104 COURTNEY ROAD, BALTIMORE, MD#27

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or other pleca)*: SPEEDVILLE CEMETERY. Dete:

20c. Location - City or Town, Stata: MELROSE, FLORIDA

21. Signetura of Funeral Service Licensee: Rosie M. Smith

22. Name end Address of Feciility: WM. C. MARCHFH.-1101 E. NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset and Deeth
Immediete Cause (Final diseese or condition resulting in deeth) e.	Acute Anterium Myocardial Infarction	4 hours
Due to (or es e consequence of):		
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last: b.	Multivessel Coronary Artery Disease	40 yrs
Due to (or es e consequence of):		
c.	Prior Inferium myocardial infarction	5 mos
Due to (or as e consequance of):		
d.	Hypertension	40 yrs

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Hyperlipidemia

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings availeble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streat, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et tha time, dete end piece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner**: On tha basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Henry Meilman MD

29c. License number: D32106

29d. Data signed *(Month, Day, Yeer)*: 1/2/97

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): HENRY MEILMAN, MD 200 E 33rd ST. suite 631 Balto MD 21218

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 06 1997

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

97-0027-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET JEFFERSON
2. Date of Death (Month, Day, Year): JAN. 2, 1997
3. Time of Death: 1120 AM
4a. Facility Name (If not institution, give street and number): 3600 WEST FRANKLIN STREET APT.A-11
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 243-01-4847
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 22 1921
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3600 WEST FRANKLIN STREET apt A11
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping
16b. Kind of Business/Industry: City Of Baltimore

17. Father's Neme (First, Middle, Last): John Cross
18. Mother's Name (First, Middle, Meiden Surname): Etta Cross

19a. Informant's Name/Relationship (Type, Print): Mable C. Dawson/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 N. Woodington Rd, 2B, Baltimore Maryland 21229

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): BALTIMORE NATIONAL
Date: 1-9-96
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles R. Bell
22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? Limited 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Radentz, MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00064

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHNNIE OTIS JOHNSON
2. Date of Death Month: January Day: 1 Year: 1997
3. Time of Death: 5:10AM
4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 415-22-6322
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 23, 1920
9. Birthplace *(State or Foreign Country)*: Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1005 Rodman Way
10f. Zip Code: 21205
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Manager
16b. Kind of Business/Industry: Motel Industry

17. Father's Name *(First, Middle, Last)*: Dan Johnson
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Cody

19a. Informant's Name/Relationship *(Type, Print)*: Carol J. Mullins (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 38 Warren Road Middle River, Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cramatory or other place)*: Md. Veterans Cemetery
Date: 1/6/1997
20c. Location - City or Town, State: Garrison Forest, Md.

21. Signature of Funeral Service Licensee: John Bruzdzynski
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY FIBROSIS — MANY YEARS

Dua to (or as a consequance of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — MANY YEARS

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

Due to (or as a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CONGESTIVE HEART FAILURE

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case refarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neeru Gupta, M.D.
29c. License number: P05903
29d. Date signed *(Month, Day, Year)*: January 1 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEERU GUPTA, M.D. 5601 LOCH RAVEN BOULEVARD BALTIMORE MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00065

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Mercer Klakring
2. Date of Death Month Day Year: JAN 2, 1997
3. Time of Death: 8:40 AM
4a. Facility Name *(If not institution, give street and number)*: 1014 Wells Avenue
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-12-9822
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUN 28, 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1014 Wells Avenue
10f. Zip Code: 21403
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII/Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer
16b. Kind of Business/Industry: Surveying Company

17. Father's Name *(First, Middle, Last)*: Alfred Paul Klakring
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Price

19a. Informant's Name/Relationship *(Type, Print)*: Glenn Don Klakring / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12 Brooklet Avenue Easton, MD 21601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. — Date: 01/03/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bladder Cancer — 4 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute renal failure

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart E. Selonick, M.D.
29c. License number: 019838
29d. Date signed *(Month, Day, Year)*: 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart E. Selonick, M.D. 900 Bestgate Annapolis, Md. 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATIE E. KELLY
2. Date of Death Month / Day / Year: JAN. 5, 1997
3. Time of Death: 9AM
4a. Facility Name (If not institution, give street and number): Maryland Manor Nursing Home
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: A.A. Co

Funeral Director

5. Social Security Number: 230-09-4456
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-19-1898
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Maryland
10b. County: A.A. Co.
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21 Harriet Drive
10f. Zip Code: 21061
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): Thomas Walters
18. Mother's Name (First, Middle, Maiden Surname): Mc Farland

19a. Informant's Name/Relationship (Type, Print): Mr. B.L. Rodgers
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Harriet Drive Glen Burnie Md 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem. Park
Date: 1-7-97
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Thomas J. Rhoads Jr.
22. Name and Address of Facility: Raymond C. Fink Funeral Home, 426 Crain Hwy., S.W., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — Due to (or as a consequence of): — 11th
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Arteriosclerotic Cardiovascular — Due to (or as a consequence of): Disease — 20 yrs
c. — Due to (or as a consequence of):
d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D27838
29d. Date signed (Month, Day, Year): 1/6/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John S. Stamos, 5 Sycamore Rd Linthicum MD 21090

State Registrar

31. Data filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00067

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY MARIE KELLUM

2. Date of Death Month: JANUARY Day: 1 Year: 1997

3. Time of Death: 6:55 am

4a. Facility Name *(If not institution, give street and number)*: 2516 Hollins Ferry Road

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-22-3932

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 12 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2516 Hollins Ferry Road

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: City Of Baltimore

17. Father's Nama *(First, Middle, Last)*: Samuel Carter

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Crawford

19a. Informant's Name/Relationship *(Type, Print)*: Albert S. Kellum Sr/Grandson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2516 Hollins Ferry Rd, Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other placa)*: NEW TOWN CEMETERY Date: 1/7/97

20c. Location - City or Town, Stata: Easton, Maryland

24. Signature of Funeral Service Licensee: Teresa D. Powell

22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular ARRHYTHMIA — MINUTES

Due to (or es a consequence of):

b. ISCHEMIC HEART DISEASE — 5 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HIGH BLOOD PRESSURE — 10 YEARS

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

CHRONIC LUNG DISEASE

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, tarm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Gerard M Lowder

29c. Licensa number: D29296

29d. Data signed *(Month, Day, Year)*: JANUARY 6 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): GERARD M LOWDER

State Registrar

31. Date tiled *(Month, Day, Year)*: JAN 06 1997

32. Registrer's Signature: Julia Davidson-Randolph

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00068

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma K. Kratz
2. Date of Death Month: Jan Day: 1 Year: 1997
3. Time of Death: 11:45 A.M.
4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-12-3218
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 2, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5408 Knell Ave.
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Plastic Co.

17. Father's Name *(First, Middle, Last)*: Harry L. Roberts
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary C. Miller

19a. Informant's Name/Relationship *(Type, Print)*: Victoria M. Edwards
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7048 Belclare Rd., Baltimore, MD 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Crematory
Date: 1/6/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ J. George Altenburg
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebr. Ivascular thrombosis — 2 wks.

Due to (or as a consequence of):
b. Atherosclerotic cardiovascular disease — years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Rheum. toid Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Louis E. Granzer
29c. License number: D01442
29d. Date signed *(Month, Day, Year)*: Jan. 1, 1997

30. Name and address of person who completed cause of death *(Item 23a)* (Type, Print): Louis E. Granzer, M.D. 301 St. Paul Pl. 815 B.H. Md 21202

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: ▶ Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00069

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Dade Linaweaver
2. Date of Death Month Day Year: JAN 3, 1997
3. Time of Death: 12:45 PM
4a. Facility Name *(If not institution, give street and number)*: 5304 Carter Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-26-3519
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 23, 1912
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 600 Light Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Associate
16b. Kind of Business/Industry: Department Store
17. Father's Name *(First, Middle, Last)*: James E. Dade
18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Shaeker
19a. Informant's Name/Reletionship *(Type, Print)*: Elizabeth L. Quarengesser/Daughter
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 2008 Woodbourne Avenue Baltimore, MD 21239
20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: 01/04/97
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: Cremation Society of Md., Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. End Stage COPD — >5yrs.

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determinad
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier:
29c. Licensa number: D41901
29d. Date signed *(Month, Day, Year)*: January 4, 1997

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Ziad Mirza MD 3007 E Northern Parkway, Baltimore, MD 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 06 1997
32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

(12)

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dolores Lavezza

2. Date of Death: Month Jan Day 03 Year 1997

3. Time of Death: 8:25am

4a. Facility Name (If not Institution, give street and number): The Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-12-8496

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 2, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5907 Winthrope Avenue

10f. Zip Code: 21206

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter J. Meehan

18. Mother's Name (First, Middle, Maiden Surname): Katherine Brockmeyer

19a. Informant's Name/Relationship (Type, Print): Mr. Joseph F. Lavezza

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Sunflower Drive Apt. 120 Belair, Md. 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery

Date: 1/6/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mark T. Zavoyna ▶ Mark T. Zavoyna

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage — 14 days

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Severe Hypertension — Many years

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lena Sayegh MD

29c. License number: D08239

29d. Date signed (Month, Day, Year): Jan 5- 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lena Sayegh Good Samaritan Hospital 5601 Loch Raven blvd Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: ▶ Marvadson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00071

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NORMA LAVIN

2. Date of Death Month Day Year: JANUARY 3, 1997

3. Time of Death: 10:59 AM

4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-07-5746

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 1, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11630 Glen Arm Road

10f. Zip Code: 21057

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerical

16b. Kind of Business/Industry: Sears Retail Store

17. Father's Name *(First, Middle, Last)*: William H. Parks

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. Jones

19a. Informant's Name/Relationship *(Type, Print)*: David G. Lavin (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3330 Fallston Road Fallston, Md. 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 1/6/97

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Milton J. Knight Jr

22. Name and Address of Facility: Leonard J. Ruck, INc. 5305 Harford Road Baltimore, Maryland 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE PONTINE HEMORRHAGE — 6 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 42736

29d. Date signed *(Month, Day, Year)*: 1-3-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AYMAN AKKAD, M.D. 7600 OSLER DRIVE BALTIMORE, MD. 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — *Certificate of Death*

97 00072

ITEM#31 PER FIELD REP 1-6-97 FILM#G743 J.A.

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
BRUCE	SADIRICK	LEWIS	JAN 03 97	22:50

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES HOSPITAL	BALTIMORE	BALTO. CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 60 3674	1 M 2 F	44 Yrs.			1/13/52	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	BALTO. CITY	BALTIMORE	1 Yes 2 No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
639 CHARRAWAY ROAD	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	3	SHIP FITTER MECHANIC	BETHLEHEM STEEL SHIP YARD

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE W. LEWIS SR.	ELAINE D. LEWIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BARBARA LEWIS WIFE	639 CHARRAWAY POAD BALTO. MD. 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ARBUTUS PARK 1/9/97		ARBUTUS, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Paul A Estep	ESTEP BROTHERS FUNERAL HOME P.A. 1300 FUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pulmonary Embolism	MINUTES
Due to (or as a consequence of):	b. Intracranial Hemorrhage	10 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hypertension	YEARS
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alcoholism

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	N/A	N/A M	1 Yes 2 No N/A	N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A	

29a. Certifier (Check only one)

1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Sirithara M.D.	D45427	Jan. 04 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. SIRITHARA, 3455 WILKENS AVE #301, BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
~~Jan. 04 97~~	JAN 06 1997 Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00073

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma Elizabeth Miller

2. Date of Death Month Day Year: Jan 04 1997

3. Time of Death: 2300

4a. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-05-3075

6. Sex: 1☐ M 2☒ F (XX)

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 8, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10e. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☐ No (XX)

10e. Street and Number: 701 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced (XXX)

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☐ No (XXX) if Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1☐ Yes 2☐ No (XXX) Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decadent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Steel

17. Fether's Neme *(First, Middle, Last)*: John Ambrose Miller

18. Mother's Neme *(First, Middle, Maiden Surname)*: Minna Schloeman

19e. Informent's Neme/Reletionship *(Type, Print)*: Robert E. Miller Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Steta, Zip Code)*: 944 Rt 97 Cooksville, Maryland 21723

20a. Mathod of Disposition: 1☒ Buriel (XX) 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cramatory or othar piace)*: Lorraine Park Cemetery

Date: 1/7/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenaka

22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23e. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth)

e. Chronic obstructive pulmonary disease — 4 years

Dua to (or as a consequanca of):

Sequantially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

b. Dehydration

Dua to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not rasulting in the underlying cause given in Part I.

Depression

23b. Did **tobecco use contribute to the cause of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piace, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On tha basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to tha cause(s) and menner steted.

29b. Signature and title of certifier: Myla M Carpenter MD

29c. Licensa number: D 30989

29d. Data signed *(Month, Day, Year)*: Jan 05 1997

30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print): Myla M Carpenter MD 711 Maiden Choice Ln Catonsville

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Monroe

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

97-0059-033
B.K.S

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDREW IAN MOORE
2. Date of Death Month Day Year: JAN. 4, 1997
3. Time of Death: 0300 AM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 216-17-5204
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 20 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 16, 1976
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4116 Wakefield Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Timothy Ian Moore
18. Mother's Name (First, Middle, Maiden Surname): Pamela Kay Archambo

19a. Informant's Name/Relationship (Type, Print): Timothy Ian Moore/father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4116 Wakefield Ln. Bowie, MD 20715

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc. | Date: 1/6/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HEAD AND NECK INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient ☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1 4 97
28b. Time of Injury: 0200 A M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: OCCUPANT OF CAR IN COLLISION WITH TREE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State): BALTO-WASHINGTON PARKWAY, P.G CO MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Bellfield
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE A. KOROL MD, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00075

Items: 8 & 9 per F.H. G-743 1/8/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE P. MAFALE
2. Date of Death (Month, Day, Year): January 3 1997
3. Time of Death: 9:20 AM
4a. Facility Name (If not institution, give street and number): LORIEN NURSING AND REHAB CENTER
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 218-01-3800
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~1/9/04~~ January 1, 1904
9. Birthplace (State or Foreign Country): ~~CATANIA SICILY~~ CATINIA CICILIE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: FERNDALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1505 CHURCH LANE
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS
16b. Kind of Business/Industry: MENS CLOTHING

17. Father's Name (First, Middle, Last): MICHAEL PALAZZO
18. Mother's Name (First, Middle, Maiden Surname): BARBARA COSTA

19a. Informant's Name/Relationship (Type, Print): BARBARA HARRIS - DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 DINSMORE AVE. FERNDALE MARYLAND 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN CEMETERY
Date: JAN 6,97
20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Hilary C. Stallings Jr.
22. Name and Address of Facility: STALLINGS FUNERAL HOME P.A. 3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) e.	aspiration pneumonia.	week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	swallowing dysfunction.	2 months
Due to (or es a consequenca of):		
c.	Stroke	2 months
Due to (or as a consequence of):		
d.	Cerebro vascular disease.	years.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

Arteriosclerosis.
Atrial Fibrillation.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could nol be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due lo the cause(s) and manner stated.

29b. Signature and title of cartifier: ▶ Richard Wolenberg
29c. License number: D31575
29d. Dele signed (Month, Day, Year): January 6, 1997.

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): KOLO DRUBETZ 5501 Old Annapolis Rd Ellicott City MD 21042

State Registrar

31. Date filed (Month, Dey, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

Item5 1-14-97 FilmG743 W.H.Per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00076
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILLARD MURRAY
2. Deta of Death Month Dey Yaar: JANUARY 1, 1997
3. Time of Death: 10:05 P.M.
4a. Facility Nama *(If not institution, giva street and number)*: VAMHCS FORT HOWARD DIVISION
4b. City, Town, or Location of Death: FORT HOWARD
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: ~~212-12-9362~~
6. Sax: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: April 11, 1921
9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 318 N. Calhoun St.
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Maritai Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forcas? 1☒ Yas 2☐ No If Yes, Give Yeer or Detas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Afro-American

15. Decedant's Education *(Specify only highast grada compiated)*: Elementary/Secondery (0-12): 8 | College (1-4or 5+): 8
16e. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Laborer
18b. Kind of Business/Industry: Steel Company

17. Father's Neme *(First, Middla, Last)*: UnKnown
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Alice Robinson

19e. Informent's Neme/Reietionship *(Type, Print)*: Mrs. Dolores Murray (wife)
19b. Meiling Address *(Street and Number or Rurei Route Number, City or Town, Stete, Zip Code)*: 318 N. Calhoun St. Balto. Md. 21223

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Garrison Forest | Date: 1/7/97
20c. Location - City or Town, State: Owings Mills, Md.

21. Signeture of Funerai Sarvice Licensee: Joseph L. Russ
22. Neme end Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused tha daath. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heert feiiure. List only one ceuse on eech line. | Approximate interval Between Onset and Deeth

Immediate Ceuse (Finel diseese or condition resulting in death)
a. LUNG CANCER WITH BRAIN METASTASIS — 1 month
Due to (or as a consequence of):
b. PROSTATE CANCER WITH BONE METASTASIS — 3 YEARS

Sequentially list conditions, if eny, ieeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings avsilable prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes casa refarred to medical examiner? 1☐ Yes 2☒ No
26. Piace of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Menner of Death: 1☒ Naturei 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Dete of injury *(Month, Day Year)*
28b. Time of Injury M
28c. injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred et the time, dete end piece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete and piace, and dua to the cause(s) end menner stated.

29b. Signeture end title of certifier
29c. License number: D30528
29d. Data signed *(Month, Dey, Year)*: Jan 1st, 1997

30. Nema and eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR. BALA DUGGIRALA, M.D.--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

State Registrar

31. Deta filed *(Month, Dey, Year)*: JAN 06 1997
32. Registrer's Signeture

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00077

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martha MORGAN
2. Date of Death Month Day Year: January 3, 1997
3. Time of Death: 11:40 am
4a. Facility Name *(If not institution, give street end number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-10-6464
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Jan. 2,1909
9. Birthplace *(Stete or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2330 Phillips Road
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry W. Lord
18. Mother's Name *(First, Middle, Meiden Surneme)*: Margaret M. Chambers

19a. Informant's Name/Relationship *(Type, Print)*: Charles Frank (Nephew)
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2330 Phillips Road Essex, Md. 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Sacred Heart Cemetery | Date: 1/6/1997
20c. Location - City or Town, State: Bushwood, Md.

21. Signature of Funeral Service Licensee: John Bruzdzinski
22. Name end Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. Myocardial Infarction — 13 Hours

Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Chronic Atrial Fibrullation

Acute Renal Failure, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Babak Imanoel
29c. License number: RD2118
29d. Date signed *(Month, Dey, Year)*: January 3, 1997

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Babak Imanoel M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00078

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILDRED NAUNTON

2. Date of Death Month / Day / Year: JAN. 3, 1997

3. Time of Death: 4:42 AM

4a. Facility Name *(If not Institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-03-3345

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: March 21, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5 Airway Circle Apt. 3A

10f. Zip Code: 21286

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Credit Reporting

17. Father's Name *(First, Middle, Last)*: Thomas Fallon

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Hare

19a. Informant's Name/Relationship *(Type, Print)*: Alfred Charles Naunton/husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Airway Cir. Apt. 3A Towson, MD 21286

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gard.

Date: 1/6

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: John O. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy Low, M.D.

29c. License number: D 24034

29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TIMOTHY LOW, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

97-0037-510
jhm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items28e,20b 4-16-97 FilmG746 W.H.Per Doctor

Certificate of Death

97 00079
Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): TROY D. NELSON
2. Date of Death Month Day Year: JANUARY 3, 1997
3. Time of Death: 0155 AM
4a. Facility Neme (If not institution, give street and number): 1100 TRAVERS WAY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth: NA

Funeral Director

5. Social Security Number: 214-88-6433
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-30-1973
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 5806 Jonquil Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: Labor World

17. Father's Name (First, Middle, Last): Steven Lavern Nelson
18. Mother's Name (First, Middle, Maiden Surneme): Karen V. Payne

19e. Informant's Name/Relationship (Type, Print): Karen Payne - Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5806 Jonquil Avenue Baltimore, Md 21215

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Md National Memorial Park | Dete: 1-7-97
20c. Location - City or Town, Stete: Laurel, Md

21. Signature of Funeral Service Licensee: ▶ Gladys Wana
22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immedlete Cause (Finel disease or condition resulting in deeth): a. Multiple Gunshot Wounds
Due to (or as a consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last: b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death: 1☐Neturel 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day Year): 1-3-97
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Subject was shot
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1100 Travers Way, Baltimore City, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: ▶ Steph S Nacht, MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 03, 1997
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 06 1997
32. Registrar's Signeture: Julia Dickson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecilia E. Nolte

2. Date of Death (Month, Day, Year): Jan 4, 1997

3. Time of Death: 9:32am

4a. Facility Name (If not institution, give street and number): Ridgeway Manor Nursing Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-16-5900

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 23, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5743 Edmondson Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Michael P. Doyle

18. Mother's Name (First, Middle, Maiden Surname): McQuire

19a. Informant's Name/Relationship (Type, Print): Charles C. Nolte, Jr (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6832 Hayley Ridge Way, Baltimore, Md. 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: 1/7/97

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: ▶ A. Alan Seitz Jr

22. Name and Address of Facility: A. Alan Seitz, Jr. Funeral Home, 3818 Roland Avenue, Baltimore, Md 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Acute Cerebrovascular Event	2 hr.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Arteriosclerotic Cardiovascular Disease	many years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Geetha Raja MD

29c. License number: D27541

29d. Date signed (Month, Day, Year): Janvary 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GEETHA RAJA, 4367 Hollins Ferry Rd, Baltimore, MD 21227

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Luke Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter L. Overton

2. Date of Death: Month: January; Day: 2; Year: 97

3. Time of Death: 7:24 a.m.

4a. Facility Name (If not institution, give street and number): Liberty Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 238-46-8164

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 8 1933

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 1211 N. Parrish Street

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Circular Advertisement

16b. Kind of Business/Industry: Distributors

17. Father's Name (First, Middle, Last): Haywood Overton

18. Mother's Name (First, Middle, Maiden Surname): Patty Overton

19a. Informant's Name/Relationship (Type, Print): Edith Overton/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1211 N. Parrish Street, Baltimore Maryland 21217

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 1/7/97

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles F. Powell

22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sudden cardiac arrest	2 1/2 hours
Due to (or as a consequence of): b.	Stroke post subtotal colectomy	2 1/2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Carcinoma of the colon-extensive	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lenox S. Dingle MD

29c. License number: D24355

29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lenox S. Dingle M.D. 301 St. Paul Place Suite 420 Balto. MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00082

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): KENNETH Chauncey PROCTOR

2. Dete of Death Month: January Dey: 04 Yeer: 1997

3. Time of Death: 05:15 pm.

4a. Facility Neme (If not institution, give street end number): Church Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Sacurity Number: 213-38-9969

6. Sex: 1☐M 2☐F XX

7. Aga (In yrs. last birthday): 89 Yrs. If Under 1 Yaar: Months / Deys. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): August 17,1907

9. Birthplace (Stete or Foraign Country): Washington DC

Usuel Residance of Dacedent

10e. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No XXX

10e. Street and Number: 101 Cross Keys Road Apt B

10f. Zip Code: 21210

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Married XXX Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forces? XXX Yes 2☐ No WWII If Yas, Give Yeer or Detes:

13. Wes Decedant of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1☐ Yes XXX No Specify:

14. Rece - Amaricen indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elemantery/Secondery (0-12): College (1-4or 5+): 5+

16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Judge

16b. Kind of Business/Industry: Baltimore Co. Circuit

17. Fether's Nema (First, Middle, Last): Frederick Russell Proctor

18. Mother's Neme (First, Middle, Maiden Surname): Gertrude Chauncey

19a. Informent's Neme/Reletionship (Type, Pnint): Margaret L. Proctor Wife

19b. Meiling Address (Streat end Numbar or Rural Route Number, City or Town, Stete, Zip Code): 101 Cross Keys Road Apt B Baltimore, Maryland 21210

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removei from State 4☐ Donetion 5☐ Other (Specify) XX

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Greenmount Cemetery

Deta: 1/6/96

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Sfyridakis

22. Name end Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complications thet caused tha deeth. Do not anter the mode of dying, such as cardiec or raspiratory arrast, shock, or heert failura. List only ona cause on eech lina.

Approximeta Interval Between Onset end Deeth

Immedieta Cause (Final diseese or condition resulting in death) e. Aspiration Pneumonia — 1 day

Due to (or as a consequenca of):

Sequentielly iist conditions, if any, leading to immediete cause. Entar Underlying Cause (Diseese or injury thet initieted evants resulting in deeth) Last

b. Sepsis — 1 day

Due to (or es e consequence of):

c.

Due to (or as e consequenca of):

d.

Part ii. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availebie prior to completion of ceusa of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yas 2☒ No

26. Pieca of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Othar (Specify)

27. Menner of Deeth: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of injury (Month, Dey Year)

28b. Time of injury M

28c. injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, daeth occurred et tha tima, date and piece, end dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the cause(s) and manner steted.

29b. Signatura and titla of certifiar: M.A. Jaydem MD

29c. License number: D 51010

29d. Date signed (Month, Day, Year): January, 04, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Muhammad Jaydem, MD - CHURCH HOME HOSPITAL.

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Julia Jordan-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00083

Reg. No.

ITEM#5 PER F.H. 1-21-97 FILM#G743 J.A.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRED L PRETTY
2. Date of Death Month: JANUARY Day: 4 Year: 1997
3. Time of Death: 4:15 PM
4a. Facility Name (If not institution, give street and number): WASHington Adventist Hospital
4b. City, Town, or Location of Death: TAKOMA Park
4c. County of Death: MONTgomery

Funeral Director

5. Social Security Number: 239-26-4013 (40)
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 7, 1929
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6404 OSborn Road
10f. Zip Code: 20784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MINISTER
16b. Kind of Business/Industry: Baptist Church

17. Father's Name (First, Middle, Last): Joseph Sims
18. Mother's Name (First, Middle, Maiden Surname): Luetta Day

19a. Informant's Name/Relationship (Type, Print): Mary D. Pretty - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6404 OSborn Road Hyattsville Maryland 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): QUANTICO NATIONAL CEM.
Date: 1/10/97
20c. Location - City or Town, State: Triangel, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert B Baker Jr.
22. Name and Address of Facility: CHINN Funeral Service 2605 So. Shirlington Rd. ARL. Va. 22206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Respiratory failure	6 days
Due to (or as a consequence of): b.	Streptococcal Pneumonia	9 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Chronic Obstructive Pulmonary disease	10 yrs
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Sepsis, Acute Renal failure Diabetes Mellitus, Coronary artery disease, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ R Ashby MD
29c. License number: D31326
29d. Date signed (Month, Day, Year): JANUARY 5, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Richard B. ASHby 8730 GA. AVE. Silver Spring, Md 20910

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH VIRGINIA PLUNKERT
2. Date of Death (Month, Day, Year): January 3, 1997
3. Time of Death: 1030 AM
4a. Facility Name (If not institution, give street and number): 5502 W. North Ave.
4b. City, Town, or Location of Death: Woodlawn
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-01-6971
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5502 W. North Ave.
10f. Zip Code: 21207
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist & Switchboard Operator
16b. Kind of Business/Industry: Maryland Co-op Milk Producers
17. Father's Name (First, Middle, Last): Claude Nauman
18. Mother's Name (First, Middle, Maiden Surname): Pearl Speaks
19a. Informant's Name/Relationship (Type, Print): Mrs. Judy Shaver (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Pine St. Carrboro, NC 27510
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Good Shepherd Cemetery
Date: 1-6-97
20c. Location - City or Town, State: Ellicott City, Maryland
21. Signature of Funeral Service Licensee: John K Ashley
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ischemic heart disease, prior myocardial infarction 1989

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Barry S Walters
29c. License number: D19698
29d. Data signed (Month, Day, Year): 01/06/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 8600 Liberty Rd Randallstown, Md 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00085

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis C. Pomory

2. Date of Death: Month: January Day: 05 Year: 1997

3. Time of Death: 06:15

4a. Facility Name (If not Institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-07-2445

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 9, 1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1424 Woodall Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Yaar or Dates: NAVY WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed)

Elemantary/Secondary (0-12): 9th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Welder

16b. Kind of Business/Industry: Shipping

17. Father's Nama (First, Middle, Last): Mark Pomory

18. Mothar's Name (First, Middle, Maiden Sumame): Elizabeth Bakos

19a. Informant's Name/Relationship (Type, Print): Robert M. Pomory / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 E. Maple Rd. Linthicum, MD 21090

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cematery, crematory or other place): Green Mount Crematory

Date: Jan. 7, 1997

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Balto MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause in each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott Becker, M.D.

29c. Licansa number: P 10549

29d. Data signed (Month, Day, Year): January 05, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Scott Becker, M.D. Mercy Medical Center, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Ethelyn	H.	Richardson	January 2 1997	7:22 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Blakehurst Retirement Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-20-9270	1☐ M 2☒ F	75 Yrs.			Oct. 26, 1921	Rochester, N.Y.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore Co.	Towson	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1055 West Joppa Road Apt. 412	21204	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	04	Home Maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Erwin J.W. Huber	Ethel Brown

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Erwin W. Huber	620 Chestnut Ave. Towson, Maryland 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Corp.	01/04/97	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jeffrey L. Gair Jeffrey L. Gair	Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PANCREATIC CANCER	6 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D29373	1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ERIC J. SEIFTER 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 06 1997	Judith Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

97-0053-510
CMK ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM g-743 1/14/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILFRED RAY
2. Data of Death Month Day Year: JANUARY 03,1997
3. Time of Death: 2320PM
4a. Facility Name (If not institution, give street end number): J.H.H. BAYVIEW MEDICAL CENTER E.R.
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-88-9265
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Dec.18,1961
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Turners Station
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 811 N. Avondale Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): G.E.D. | College (1-4or 5+):
18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker
16b. Kind of Business/Industry: General Motors
17. Father's Name (First, Middle, Last): Robert Ray
18. Mother's Neme (First, Middle, Meiden Surneme): Rebecca Curbean
19a. Informent's Name/Relationship (Type, Print): Rebecca Ray/mother
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 811 N. Avondale Rd. BAlto., MD 21222
20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)
20b. Piace of Disposition (Neme of cemetery, cremetory or other piece): King Memorial Park
Date: 1/10/97
20c. Location - City or Town, State: Randallstown, MD
21. Signature of Funeral Service Licensee: James A Morton
22. Name and Address of Facility: JAmes A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21222

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yee 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No
26. Piace of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Daath: 1☐Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined
28a. Date of Injury (Month, Dey Year): 1-3-97
28b. Tima of Injury: UNKNOWN M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND IN APARTMENT
28f. Location (Street end Number or Rural Route Number, City or Town, State): 2035 BEAR RIDGE RD. DUNDALK, MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and piace, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Clarke MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): JANUARY 04, 1997
30. Name end address of person who completed cause of death (Item 23e) (Type, Print): JLAYON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 0 6 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilma S. Schlag
2. Date of Death (Month, Day, Year): January 3 1997
3. Time of Death: 1:25 AM
4a. Facility Name (If not institution, give street and number): Edenwald Retirement Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-40-5016
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 20 1904
9. Birthplace (State or Foreign Country): Indiana

Usual Residance of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Rd.
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) | College (1-4or 5+): +7
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher/Counselor
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): William Henry Sudhoff
18. Mother's Name (First, Middle, Maiden Surname): Anna E. Lippert

19a. Informant's Name/Relationship (Type, Print): Paul S. Keyser/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 Bosley Rd. Cockeysville, Md. 21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or othar place): Hilltop Service Co. | Date: 1-4-97
20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

		Approximate Interval Between Onset and Death
Immediate Cause (Finai disease or condition resulting in death) a.	— Congestive heart failure	24 hr
Due to (or as a consequenca of): b.	— Atherosclerotic disease	10 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	— Hypertension	10 yrs
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piaca of Injury - At home, farm, atreet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Physician
29c. License number: D29769
29d. Date signed (Month, Day, Year): 1/3/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence D. Ulverne 516 N. Rolling Rd Balto

State Registrar

31. Date filed (Month, Day, Year): JAN 03 1997
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH JOHNSON STRAIN

2. Date of Death (Month, Day, Year): January 1, 1997

3. Time of Death: 9:30 A.M.

4a. Facility Name (If not institution, give street and number): 2220 Furnace Road

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-01-1791

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 19, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Loch Raven Village

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1845 Loch Shiel Road

10f. Zip Code: 21234

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Henry H. Johnson

18. Mother's Name (First, Middle, Maiden Surname): Clyde L. Williams

19a. Informant's Name/Relationship (Type, Print): Timothy C. Strain Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1845 Loch Shiel Road Baltimore, Maryland 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 1/6/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Towson, Maryland 21204 — Ruck Towson Funeral Home, Inc. 1050 York Rd.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. end stage Chronic obstructive lung disease — several years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: cor-pulmonale

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffery Cool MD

29c. License number: D34650

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeffery Cool, M.D. 5600 Loch Raven Blvd.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00090

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth C. Schaitz

2. Date of Death Month: 1 Day: 3 Year: 1997

3. Time of Death: 7:45 AM

4a. Facility Name *(If not institution, give street and number)*: Augsburg Lutheran Home

4b. City, Town, or Location of Death: Lochearn

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-7471

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 28, 1899

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 5405 Summerfield Avenue

10f. Zip Code: 21206

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retirad)*: Bookkeeper

16b. Kind of Businass/Industry: Insurance

17. Father's Nama *(First, Middle, Last)*: Henry Greif

18. Mother's Nama *(First, Middle, Meiden Surname)*: Elizabeth Sause

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Laura B. Foote / Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Coda)*: R.R. 2 Box 2860 Palmyra, Maine 04965

20e. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Parkwood Cemetery

Date: 1/7/97

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Servica Licansee: Mark T. Zavoyna ▶ Mark T. Zavoyna

22. Name end Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the daath. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line.

Approximate Interval Batween Onset end Death

Immediata Cause (Final disease or condition resulting in death): a. Myocardial Infarction

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?: 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Rasidenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work?: 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office buiiding, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificata be executed within 24 hours after death.

To the Funeral Director: After this cartificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis of axamination and/or Investigation, in my opinion, daath occurred at the time, date and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Raymond Miller MD

29c. License number: D47683

29d. Dete signed *(Month, Dey, Year)*: 1/3/97

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Raymond Miller, M.D. 7220 Park Heights Ave Baltimore MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00091

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*	2. Date of Deeth Month / Day / Year	3. Time of Deeth
Lawrence Frank Sapia	January 02 1997	4:30 pm

4e. Feclity Neme *(If not institution, giva street and number)*	4b. City, Town, or Location of Deeth	4c. County of Death
2618 E. Madison Street	Baltimore	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Dey, Yeer)*	9. Birthplece *(Stete or Foreign Country)*
213-18-3570A	1☒M 2☐F	81 Yrs.			4-20-1915	S.Amboy,N.J.

Usuel Residence of Decedant

10a. Steta	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2618 E. Madison Street	21205	USA

11. Meritel Stetus	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Ricen, etc.)	14. Race - American Indien, Black, White, atc.
1☐Navar Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Giva Yaer or Detes: 3/1944 to 1/1946	1☐Yes 2☒No *Specify:*	*Specify:* White

15. Decedent's Eduction *(Specify only highest grada completed)*		16a. Decedant's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	18b. Kind of Businass/Industry
Elemantary/Secondery (0-12)	College (1-4or 5+)		
6th		Waiter	Miller Brothers

17. Fether's Nema *(First, Middle, Last)*	18. Mother's Neme *(First, Middle, Meiden Surneme)*
Salvatore Sapia	Jennie Fusco

19e. Informant's Name/Reletionship *(Type, Print)*	19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Steta, Zip Code)*
Daughter Margaret Modesto	3516 E. Fairmount Avenue Baltimore, Md. 21224

20e. Method of Disposition	20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*	Dete	20c. Location - City or Town, Steta
1☒Buriel 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Othar *(Specify)*	Gardens of Faith Cemetery	1/6/96	Baltimore, Maryland

21. Signature of Funarel Service Licensee	22. Nama and Address of Feciliity
Joseph N. Zannino Jr.	Joseph N. Zannino Jr. Funeral HM 263 S. Conkling St. Baltimore, Md. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediete Cause (Fina disease or condition resulting in death)	a. Lung cancer	2 months
	Due to (or es a consequance of):	
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted evants resulting in death) Lest	b. Due to (or es a consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒Yes 2☐No 3☐Probably 4☐Unknown

24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was cese referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Homa 5☒Residence 8☐Other *(Specify)*

27. Manner of Death	28a. Date of Injury *(Month, Dey Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yas 2☐No	
	28a. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*			28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*

1☒**Certifying Physician:** To tha best of my knowledga, deeth occurred et the time, deta and piece, end due to tha causa(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daeth occurred at the time, dete and place, and due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier	29c. Licensa number	29d. Data signed *(Month, Day, Year)*
Sandra Marshall MD	D35363	1/3/97

30. Nama end address of person who completed ceuse of death (Item 23a) (Type, Print)

Sandra Marshall MD Baltimore VA Medical Center 10 N. Greene St. Baltimore, Md. 21201

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
JAN 06 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Schoff

2. Date of Death Month/Day/Year: 01 / 01 / 97

3. Time of Death: 8:15 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-24-2207

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/12/1928

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7210 Greenbank Rd.

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): Unk.

College (1-4or 5+): Unk.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Shipping

17. Father's Name (First, Middle, Last): George Schoff

18. Mother's Name (First, Middle, Maiden Surname): Minnie Roeder

19a. Informant's Name/Relationship (Type, Print): Vernon Schoff/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7210 Greenbank Rd. Baltimore, MD 21220

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Date: 1/3/1997

20c. Location - City or Town, State: Baltimore City, MD

21. Signature of Funeral Service Licensee: Bernard Dabrowski

22. Name and Address of Facility: B. Dabrowski & Son Funeral Home P.A. 2818 E. Baltimore St. Baltimore, MD 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	sepsis	1 wk.
Due to (or as a consequence of): b.	failure to thrive	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	cerebral vascular accident	1 month
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

recent pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K Colley MD Medical Intern 96705 JHBMC

29c. License number

29d. Date signed (Month, Day, Year): 01/01/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Colley MD 4940 Eastern Ave Balto MD 21224 (Johns Hopkins Bayview Med Ctr.)

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00093

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna E. Unger
2. Data of Daath — Month: January Day: 5 Yaar: 1997
3. Tima of Death: 12:50pm
4a. Facility Nama *(If not institution, giva street and number)*: Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Sacurity Number: 220-07-2906
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Yaar — Months / Days
If Under 24 Hrs. — Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Aug. 21, 1915
9. Birthplaca *(Stata or Foraign Country)*: MARYLAND

Usual Rasidanca of Decedant

10a. Stata: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: Lockeysville - Timonium
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 12 Hollis Court
10f. Zip Code: 21093
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorcad
12. Was Decedent Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 1☐ Yas 2☒ No *Spacify:*
14. Race - Amarican Indian, Black, White, atc. *Spacify:* WHITE
15. Decedent's Education *(Spacify only highast grada completad)* — Elamantary/Secondary (0-12): 12 YRS. — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: AT HOME
16b. Kind of Businass/Industry: HOUSEWIFE
17. Fathar's Nama *(First, Middla, Last)*: ADAM TAYLOR
18. Mothar's Name *(First, Middla, Maidan Surnama)*: SNYDER
19a. Informant's Name/Rolationship *(Type, Print)*: ROLAND L. UNGER
19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 8 WINELEAF COURT HUNT VALLEY MARYLAND 21030
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: FORK UNITED METHODIST
Data: JAN. 8 1997
20c. Location - City or Town, Stata: FORK, MARYLAND
21. Signatura of Funaral Sarvica Licansad: [signature]
22. Nama and Addrass of Facility: EVANS CHAPEL OF CHIMES 2225 YORK ROAD - TIMONIUM

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one ceusa on aach line.

Approximata Intarval Between Onset and Death

Immadiata Cause (Finel disaasa or condition rasulting in death)
e. Respiratory Arrest
Due to (or as a consaquanca of):
b. Pneumonia
Saquantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Due to (or as a consaquanca of):
c. Chronic Obstructive Pulmonary Disease
Due to (or as a consaquanca of):
d. Thrombocytopenia

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to compiation of ceusa of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examiner? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Hama 5☐ Rasidance 6☐ Othar *(Spacify)*

27. Manner of Death: 1☑ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describa how injury occurrad
28a. Placa of Injury - At hama, farm, straat, factory, office building, atc. *(Spacify)*
28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Cartifying Phyaician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha ceusa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axaminetion and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the ceusa(s) and mannar stated.

29b. Signatura and titla of cartifiar: Clara Herrin MD
29c. License number: AS 240 2321
29d. Data signad *(Month, Day, Yaar)*: January 5, 1997

30. Nama and addrass of parson who completad ceusa of daath (Itam 23a) (Type, Print): Herrin, Clara MD Sinai Hospital Baltimore, MD

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 06 1997
32. Rajistrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00094

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLANCHE CAROLINE WRIGHT

2. Date of Death Month / Day / Yaar: JANUARY 2, 1997

3. Time of Death: 05:32 am

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-12-1581

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 27, 1914

9. Birthplace *(State or Foreign Country)*: Baltimore

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 711 Academy Road

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: William Austin Seiler

18. Mother's Name *(First, Middla, Maidan Surname)*: Catherine Keebler

19e. Informant's Neme/Reletionship *(Type, Print)*: Warren Wright (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29 Northwood Drive Merrimack, New Hampshire 03054

20e. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetary, crematory or other place)*: Parkwood Cemetery

Dete: 1-6-97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Sarvice Licensee: George J Fenaman

22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Intarval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute myocardial Infarction

Due to (or as a consequenca of):

b. Ventricular tachycardia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Diabetes Mellitus

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabla prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D28236

29d. Date signed *(Month, Day, Year)*: Jan 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dorian St Martin MD 5941 Old Frederick Rd, Balt 21229

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signatura: Julia Patterson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit

97-0005-510

asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00095

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TRAVIS WOODSON
2. Date of Death: Month JAN Day 01 Year 1997
3. Time of Death: 3:04 A
4a. Facility Name (If not institution, give street and number): 1800 BLK BARCLAY ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: h/q

Funeral Director

5. Social Security Number: 219-92-1825
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 17 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-31-79
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2516 GARRETT Avenue
10f. Zip Code: 21218
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent'a Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Student

17. Father's Neme (First, Middle, Last): John Paul Woodson
18. Mother's Name (First, Middle, Maiden Surneme): Glynese Lassiter

19a. Informant'a Neme/Relationship (Type, Print): Glynese Grissom
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2516 Garrett Avenue Baltimore, Md. 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Garden Date: 01-06 -97
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Vanessa Cole
22. Name and Address of Facility: Baltimore, Maryland WM.C. March FH 1101 E. North Avenue 21202

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch es cerdiec or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death)
a. MULTIPLE GUNSHOT WOUNDS
Due to (or as a consequence of):
b.
Due to (or as a consequenca of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yee 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE
27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 1 1 97
28b. Time of Injury: 0300A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: GUNSHOT
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rurel Route Number, City or Town, State): 1800 BLK BARCLAY BALTIMORE MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner es stated. 2 [X] **Medical Examiner:** On the basis of exemination and/or investigetion, In my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner steted.
29b. Signature end title of certifier: Marjorie Bracht MD
29c. License number: O.C.M.E
29d. Dete signed (Month, Day, Year): JANUARY 01,1997

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYDAWN S. KOPOSH MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00096

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LESTER N. WHITE, JR.

2. Date of Death Month Day Year: JAN. 03 1997

3. Time of Death: 2:25 PM

4a. Facility Name (If not institution, give street and number): Maryland Manor Convalescent Center

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-22-9008

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 14, 1927

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1160 Carroll Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physically Disabled

16b. Kind of Business/Industry: Never Worked

17. Father's Name (First, Middle, Last): Lester Null White

18. Mother's Name (First, Middle, Maiden Surname): Lillian Mozelle Hall

19a. Informant's Name/Relationship (Type, Print): Nancy C. Henderson / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Oak Grove Rd. Linthicum, MD 21090

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 01/04/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb

22. Name and Address of Facility: Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF LUNG — 1 YEAR

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 11 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE — 34 YEARS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh M.D.

29c. License number: D14160

29d. Date signed (Month, Day, Year): JAN. 03, 1997

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): HARJIT SINGH M.D. 5410 A RITCHIE HIGHWAY BALTIMORE, MARYLAND. 21225

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00097

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): LOUISE FRANCES WHITE
2. Date of Deeth — Month: January Day: 3 Year: 1997
3. Time of Death: 7:40 PM
4a. Facility Neme (If not institution, give street end number): Genesis Eldercare - Perring Parkway
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-16-8262
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 25, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 123 W. 29th St.
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Dacadent's Education (Specify only highest grade complated): Elementary/Secondary (0-12): Unknown — Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Department Store

17. Fathar's Name (First, Middle, Last): Earl C. White
18. Mother's Name (First, Middle, Maiden Surname): Catherine V. Dean

19a. Informant's Name/Ralationship (Type, Print): R. George Altenburg
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6009 Harford Rd., Baltimore, MD 21214

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Spacify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Green Mount Crematory — Date: 1/7/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ R. George Altenburg
22. Name end Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Causa (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disea — 2 YRS

Due to (or as a consequanca of):
b. Diabetes mellitus — more than 2 YRS

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Dementia.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causes of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residance 8☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To the bast of my knowladge, death occurred at tha time, date and placa, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D30641
29d. Date signed (Month, Day, Year): 1/5/97

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Suite 308 821 N. Eutaw St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: [signature] Lia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00098

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard C. Wagner, Sr.

2. Date of Death — Month: January; Day: 2; Year: 1997

3. Time of Death: 21:22 PM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-32-9526

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9/25/35

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 122 TRAILWAY ROAD

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INSULATOR

16b. Kind of Business/Industry: WORKERS INSULATION LOCAL #11

17. Father's Name *(First, Middle, Last)*: LEROY WAGNER

18. Mother's Name *(First, Middle, Maiden Surname)*: MARIE DEFONTES

19a. Informant's Name/Relationship *(Type, Print)*: SHELIA WAGNER WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 122 TRAILWAY ROAD BALTIMORE, MD 21220

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY, INC. Date: 1/5/97

20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: Christina L. Kopczyk

22. Name and Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Asystolic arrest	5 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — b.	Coronary Artery Disease	8 years
Due to (or as a consequence of):		
c.	Carotid occlusive disease	5 years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Linda D. Burkhardt, MD

29c. License number: D45862

29d. Date signed *(Month, Day, Year)*: Jan 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA D. BURKHARDT 201 E. UNIVERSITY PKWAY BALTIMORE, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Item21 1-6-97 FilmG743 W.H.Per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dia D Wright

2. Data of Death — Month: JANUARY Day: 1 Yaar: 1997

3. Tima of Death: 7 07 P.M.

4a. Facility Nama (If not institution, giva street and number): University of Maryland

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 218-98-8548

6. Sax: 1☐ M 2☑ F

7. Aga (In yrs. last birthday): 17 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Yaar): May 21, 1979

9. Birthplaca (Stata or Foreign Country): Maryland

Usual Rasidance of Dacedant

10a. Stata: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☑ Yas 2☐ No

10e. Street and Number: 1608 W. Lexington St, Apt. J.

10f. Zip Coda: 21223

10g. Citizan of What Country? U.S.A

11. Marital Status: 1☑ Navar Marriad 2☐ Marriad 3☐ Widowad 4☐ Divorcad

12. Was Dacadant Evar in U.S. Armad Forcas? 1☐ Yas 2☑ No — If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☑ No Specify:

14. Race - Amaricen Indian, Black, White, atc. Specify: Black

15. Dacadant's Education (Specify only highast grada compliatad) — Elamantary/Saconday (0-12): 11th — Collaga (1-4or 5+):

16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): Student

16b. Kind of Businass/Industry: N/A

17. Fathar's Nama (First, Middla, Last): Erik Wright

18. Mothar'a Nama (First, Middla, Maidan Surnama): Gerstine Fields

19a. Informant's Name/Ralationship (Type, Print): Gerstine Fields

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1608 W. Lexington St, Apt J. Balt, MD 21223

20a. Mathod of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): King Mem. Pk. — Data: 1/7/97

20c. Location - City or Town, Stata: Baltimore MD.

21. Signatura of Funaral Sarvica Licansaa: Gary P. March

22. Nama and Address of Facility: Gary P. March Funeral Home P.A. 270 Fredrick Pass Balt. MD. 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part. Enter the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. Respiratory Failure

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last

b. Pleural Effusion

Dua to (or as a consaquanca of):

c. Metastatic Fibrosarcoma

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compliation of ceusa of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona) — Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not ba datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Dascribe how injury occurrad

28a. Placa of injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifiar: Karen Dettmer MD

29c. Licansa number: P08648

29d. Data signad (Month, Day, Yaar): Jan 2, 1997

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Karen S. Dettmer M.D. UMMS 22 S. Greene St. Balto., MD 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Data filad (Month, Day, Yaar): JAN 06 1997

32. Registrar's Signatura: Lydia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00100

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Zion

2. Date of Death: Month: Jan; Day: 2; Year: 1997

3. Time of Death: 09 30 am

4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-64-4476

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 13, 1951

9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 5200 Ballman Avenue Unit#7

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: General Contractor

17. Father's Name *(First, Middle, Last)*: Charles W. Zion

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Sawyer

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Sawyer (mother) Jean Hatcher (aunt)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1809 Bluemont Avenue Roanoke, Virginia 24015

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sherwood Memorial Park

Date: Jan 6

20c. Location - City or Town, State: Salem, Virginia

21. Signature of Funeral Service Licensee: Herbert E. Nutter

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral herniation — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Subdural hematomas — 10 days

Due to (or as a consequence of):

c. cerebral infarction — 10 days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: aspiration pneumonia

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J Sostak MD

29c. License number: 58626

29d. Date signed *(Month, Day, Year)*: Jan 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. SZOSTAK DEPT OF SURGERY University of Maryland Medical Center

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1997

32. Registrar's Signature: Madison-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa Josephine Altiere

2. Date of Death Month Dey Year: 01/05/1997

3. Time of Death: 7:10 PM

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-44-4052

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/28/1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 26 S. Chester Street

10f. Zip Code: 21231

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Anthony Carullo

18. Mother's Name (First, Middle, Maiden Surname): Josephine Picariello

19a. Informant's Name/Relationship (Type, Print): Josephine Scheuerman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 907 Woodbridge Ct. Edgewood, Maryland 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemetery

Date: 1/1/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John J. Offutt, Jr.

22. Name and Address of Facility: The Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE MYOCARDIAL INFARCTION	hour
Due to (or as a consequence of): b.	CARDIAC DYSRHYTMIA	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	THORACO ABDOMINAL ANEURYSM	years
d.	WITH INTRALUMINAL THROMBUS	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

CHOLELITHIASIS

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ceballos, MD

29c. License number: D 25886

29d. Date signed (Month, Day, Year): 1-6-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L. CEBALLOS, M.D. - O'DEA MEDICAL ARTS - 7505 OSLER DR - Suite 501 TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Kathleen Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(20)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00102

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTON ASHBY

2. Date of Death Month Day Year: JANUARY 2 1997

3. Time of Death: 4:25 PM

4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 135-01-5616

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 9, 1904

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5755 Oklahoma Rd.

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Supervisor

18b. Kind of Business/Industry: N.J. Bell Telephone

17. Father's Name *(First, Middle, Last)*: Willard S. Ashby

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Gladstone

19a. Informant's Name/Relationship *(Type, Print)*: Charles Ashby (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5755 Oklahoma Rd. Sykesville MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Belle Haven Cemetery

Date: 1/4/97

20c. Location - City or Town, State: Belle Haven, VA.

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight

22. Name and Address of Facility: Haight Funeral Home P.O. Box 195 Sykesville MD 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 2 weeks

Due to (or as a consequence of): b. Cerebrovascular Accident — 5 mins

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D44505

29d. Date signed *(Month, Day, Year)*: January 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AJ IMPERIAL Jr. — NWHC

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: ▶ Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

(20)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00103

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin J. Breitenbach
2. Date of Death (Month, Day, Year): January 5 1997
3. Time of Death: 1:00P
4a. Facility Name (If not institution, give street and number): Frederick Villa Nursing Center
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-01-4410
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 29, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 925 Grove Hill Road
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): chaueffer
16b. Kind of Business/Industry: trucking
17. Father's Name (First, Middle, Last): Charles Breitenbach
18. Mother's Name (First, Middle, Maiden Surname): Charlotte Ohler
19a. Informant's Name/Relationship (Type, Print): Eleanor Breitenbach, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 925 Grove Hill Road Arbutus, Maryland21227
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1/8/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Paul W. Hogan
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	myocardial infarction	<1d
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	multiple strokes	5yr.
Due to (or as a consequence of):		
c.	acute + chronic bronchitis	5yr.
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Physician
29c. License number: D29769
29d. Date signed (Month, Day, Year): 1/6/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mir Fazlin D. Abbasi MD 516 W. Rolling Rd Balto.

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00104

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLINTON BRINKLEY

2. Date of Death: Month January Day 1 Year 1997

3. Time of Death: 3:35 A.M.

4a. Facility Name (If not institution, give street and number): STELLA Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 238-48-7681

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 14, 1930

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: ESSEX

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10a. Street and Number: 209 Middlebury Road Apt. 1B

10f. Zip Code: 21220

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fork Lift Operator

16b. Kind of Business/Industry: J. Norman Geipe, Company

17. Father's Name (First, Middle, Last): Sam Brinkley

18. Mother's Name (First, Middle, Maiden Surname): Sarah Jane Richardson

19a. Informant's Name/Relationship (Type, Print): Dale Brinkley, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Middlebury Road #1B Essex Maryland 21220

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hills Cemetery

Date: 1/6/97

20c. Location - City or Town, State: Essex, Maryland

21. Signature of Funeral Service Licensee: Jerry Harris

22. Name and Address of Facility: Chatham-Harris Funeral Home, 5240 Reisterstown Road, Baltimore, Maryland 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. HYPERCALCEMIA — weeks

Due to (or as a consequence of):
b. LUNG CANCER, NONSMALL CELL — 1 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kendall R Faulkner

29c. License number: D25643

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00105

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mina Benesch

2. Dete of Deeth: Month: January Dey: 2 Year: 1997

3. Time of Death: 23:51 p

4a. Fecility Neme *(If not Institution, give street end number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 214-26-4168

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 89 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: MAR.7,1907

9. Birthplece *(Stete or Foreign Country)*: RUSSIA

Usuel Residence of Decedent

10a. Stete: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 725 MT. WILSON LANE, APT. 312

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme *(First, Middle, Last)*: CHARLES SUTTLEMAN

18. Mother's Neme *(First, Middle, Meiden Surneme)*: IDA HIMELFARB

19a. Informent's Neme/Reletionship *(Type, Print)*: HOWARD BLANK (SON)

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3404 DEEP WILLOW AVE. BALTO., MD 21208

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: BETH TFILOH

Dete: 1/5/97

20c. Locetion - City or Town, Stete: BALTIMORE, MD

21. Signeture of Funerel Service Licensee ▶ [signature]

22. Neme and Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Acute Myocardial Infarction

Due to (or as a consequenca of):

Sequentiolly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

b. Atherosclerotic Heart Disease

Due to (or es e consequence of):

c. Hypertension

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Diverticulitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Plece of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Street and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es stated. 2☐ **Medicel Examiner:** On the basis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier ▶ [signature] MD

29c. License number: MS 24 0232 1 BC 9021

29d. Dete signed *(Month, Dey, Yeer)*: January 2, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): 2401 W. Belvedere Avenue, Baltimore, MD 21215

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 07 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00106

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: OLGA BUCCINO

2. Date of Death Month: 01 Day: 04 Year: 97

3. Time of Death: 2:00 AM

4a. Facility Name *(If not Institution, give street and number)*: GENESIS CROMWELL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-03-3698

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 01/06/1913

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 305 E. Joppa Road Apt. 703

10f. Zip Code: 21204

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Clerk

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Gioranni Buccino

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Maria Campfarno

19a. Informant's Name/Relationship *(Type, Print)*: Paul J. Redmond

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 405 Allegheny Avenue Towson, Maryland 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Crematory

Date: 1/6/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Martin J. Dippel Jr

22. Name and Address of Facility: The Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Manar Kumlendu MD

29c. License number: D21022

29d. Date signed *(Month, Day, Year)*: 1-6-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): M. KUMLENDU MD 8604 HARFORD rd

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: ▶ Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00107

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JOHN 6 COWDEN

2. Dete of Death Month: JAN Dey: 06 Year: 1997

3. Time of Death: 12:10PM

4a. Facility Neme *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITOL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 153-01-2199

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Jan. 18, 1904

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Rockdale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8329 Merrymount Drive

10f. Zip Code: 21244

10g. Citizen of What Country?: United States

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WWII

13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): +2 College (1-4or 5+)

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: calculator

16b. Kind of Business/Industry: race track

17. Fether's Neme *(First, Middle, Last)*: Peter G. Cowden

18. Mother's Neme *(First, Middle, Meiden Surname)*: Rosa Poling

19e. Informent's Name/Reletionship *(Type, Print)*: Eileen McGrow, Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2 Southerly Court 606 Towson, Maryland21286

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Dete: 1/7/97

20c. Location - City or Town, Stete: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Paul Hagan

22. Name end Address of Feclility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, euch es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): e. aspiration pneumonia — about 12hours

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. multiple strokes

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: multi-infarct dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, etreet, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Jeffrey Cool MD

29c. License number: D24650

29d. Dete signed *(Month, Day, Year)*: 1/6/97

30. Neme end Address of person who completed cause of deeth (Item 23a) (Type, Print): JEFFREY COOL, M.D. 5601 LOCH RAVEN Boulevard GOOD SAMARITAN HOSPITOL

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 07 1997

32. Registrer's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#4c PER F.H. FILM#G743 1-7-97 J.A. *Certificate of Death*

Reg. No. 97 00108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sarah Cohen

2. Date of Death — Month: JAN; Day: 1; Year: 97

3. Time of Death: 10:35A

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-44-4840

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 15, 1910

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3026 FALLSTAFF ROAD APT. A

10f. Zip Code: 21209

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ISADORE GREENBERG

18. Mother's Name *(First, Middle, Maiden Surname)*: REGINA GREENBERG

19a. Informant's Name/Relationship *(Type, Print)*: J. FRED COHEN / SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 100 CHURCH LANE BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHIZUK AMUNO - ARLINGTON — Date: 1/2/97

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Jay Allen Green

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTerstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Renal Failure

Due to (or as a consequence of):
b. Dehydration — 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diarrhea — 1 week

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal failure

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)* — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harry Lawens

29c. License number: D40371

29d. Date signed *(Month, Day, Year)*: 1/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr Harry W. Lawens MD 20 Crossroads Drive, Owings Mills MD 21117

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte D. Cooney
2. Date of Death Month Day Year: January 4,1997
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): 1021 Marksworth Road
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-26-3359
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/20/1909
9. Birthplace (State or Foreign Country): Belgium

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1021 Marksworth Road
10f. Zip Code: 21228
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: Doctor's Office
17. Father's Name (First, Middle, Last): Theophile DeRonge
18. Mother's Name (First, Middle, Maiden Surname): Marie Unknown
19a. Informant's Name/Relationship (Type, Print): M. Russel Cooney/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1937 Old Frederick Road Catonsville MD 21228
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park
Date: 1/7/1997
20c. Location - City or Town, State: Baltimore
21. Signature of Funeral Service Licensee: Russell D. Witzke
22. Name and Address of Facility: Witzke Funeral Home 1630 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	one week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Chronic Emphysema Sen osteoporosis/Kyphosis	10 yrs.
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JWCook MD
29c. License number: D44243
29d. Date signed (Month, Day, Year): January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JW Cook MD 516 N. Rolling Rd Suite 108 Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00110

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANK WILLIAM CURRAN SR.

2. Date of Death (Month, Day, Year): JANUARY 4, 1997

3. Time of Death: 6:45PM

4a. Facility Name *(If not institution, give street and number)*: 610 RAPPOLLA STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212282184

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 2, 1930

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 610 RAPPOLLA STREET

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4 or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COPPERSMITH

16b. Kind of Business/Industry: SHIPYARD

17. Father's Name *(First, Middle, Last)*: JOSEPH CURRAN

18. Mother's Name *(First, Middle, Maiden Surname)*: VIOLA JONES

19a. Informant's Name/Relationship *(Type, Print)*: MARIE V. CURRAN / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 610 RAPPOLLA STREET BALTIMORE, MD 21224

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Date: 1/8/97

20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer lung — 10 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] M.D

29c. License number: D18487

29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO THANT, MD 6830 HOSPITAL DR.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00111

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARlene F Coleman
2. Date of Death (Month, Day, Year): January 3 1997
3. Time of Death: 3:08AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-01-6585
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT.7,1920
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4525 DRESDEN RD.
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER/OPERATOR
16b. Kind of Business/Industry: TELEPHONE ADVERTISING SERVICE

17. Father's Name (First, Middle, Last): CHARLES TRAUB
18. Mother's Name (First, Middle, Maiden Surname): DORA JACOBSON

19a. Informant's Name/Relationship (Type, Print): MRS. ESTHER J.MONOKER (DAUG.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2323 MELINDA DR. OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOSES MONTEFIORE WOODMOOR HEBREW | Date: 1/5/97
20c. Location - City or Town, State: BALTO.,MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chimene L Libard MD
29c. License number: AS2402321 CL9010
29d. Date signed (Month, Day, Year): January 3 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Chimene L Libard MD Sinai Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00112

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Eugene Chester
2. Date of Death: Month January Dey 1 Year 1997
3. Time of Death: 0912 AM
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-28-4772
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 1, 1931
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 961 Rumsey Place
10f. Zip Code: 21085
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dental Ceramisist
16b. Kind of Business/Industry: Dental Industry

17. Father's Name (First, Middle, Last): Lawrence Chester
18. Mother's Name (First, Middle, Maiden Surname): Virginia Bowles

19a. Informant's Neme/Reiationship (Type, Print): Mrs. Mary K. Chester (Wife)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 961 Rumsey Place Joppa, Maryland 21085

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Dete: January 3,1997
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: E.F. Lassahn Funeral Home
22. Name and Address of Feciiity: E.F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087

Physician /Medicai Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Deeth
Immediate Cause (Finai disease or condition resulting in deeth) a.	CARDIO PULMONARY ARREST	1 HR.
Due to (or as a consequence of): b.	HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASC. DIS.	3 YR.
Sequentiellly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest — Due to (or as a consequence of): c.	ARTERIOSCLEROSIS, GENERALIZED	"
Due to (or as e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

CONGESTIVE HEART FAILURE

CEREBROVASCULAR ACCIDENT 1994

DIABETES MELLITUS W/RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicai exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ben Oteyza MD
29c. License number: DO 8791
29d. Date signed (Month, Day, Year): JAN. 1, 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): BEN OTEYZA, M.D. - 846 S. MAIN ST. BEL AIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOYCE VIRGINIA Davies

2. Date of Death Month Day Year: January 2, 1997

3. Time of Death: 7:40 AM

4a. Facility Name (If not institution, give street and number): Memorial Hospital at Easton

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 283-24-1344

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 7 1929

9. Birthplace (State or Foreign Country): OH

Usual Residence of Decedent

10a. State: OH

10b. County: CARROLL

10c. City, Town or Location: SHERRODSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6125 VALE VIEW DRIVE SW

10f. Zip Code: 44675

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): DAVID WALLIS

18. Mother's Name (First, Middle, Maiden Surname): ISABELLE McAREL

19a. Informant's Name/Relationship (Type, Print): BEN DAVIES, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6125 VALE VIEW DR SW SHERRODSVILLE OH 44675

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LAKE PARK CEMETERY

Date: 1-5

20c. Location - City or Town, State: YOUNGSTOWN, OH

21. Signature of Funeral Service Licensee: Phillip Starks

22. Name and Address of Facility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALT., MD. 21228

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D24769

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L. THOMAS DIVILIO, M.D. 404 MARVEL CT. P.O.BOX 822 EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be recorded within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVA DAMICO

2. Date of Death Month: JAN. Day: 3 Year: 1997

3. Time of Death: 7:30AM.

4a. Facility Name (If not institution, give street and number): 907 TRINITY ST.

4b. City, Town, or Location of Death: BALTO CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-34-8894

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 18, 1908

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 907 TRINITY ST.

10f. Zip Code: 21202

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ANTHONY PIZZA

18. Mother's Name (First, Middle, Maiden Surname): ROSE MORANTO

19a. Informant's Name/Relationship (Type, Print): GRANDDAUGHTER DOREEN D'AMICO HAYDEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 150 E. 61ST ST. NEW YORK 10021 N.Y.

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARDEN of FAITH

Date: 1/6/97

20c. Location - City or Town, State: BALTO MD.

21. Signature of Funeral Service Licensee: Donald Della Noce

22. Name and Address of Facility: DELLA NOCE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO 21202 MD.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 2 YRS.

Due to (or as a consequence of):

b. Atrial Fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Carcinoma - Colon — 2 YRS.

Due to (or as a consequence of):

d. Diabetes Mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kenneth T. Mims MD.

29c. License number: D26923

29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K. TRENT MIMS MD. 709 E. LOMBARD ST. BALTO MD. 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: L. M. Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item5 3-25-97 FilmG745 W.H.Per F/H

Certificate of Death

Reg. No. 97 00115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK DOGOLOFF

2. Data of Death: Month JANUARY Day 04 Year 1997

3. Time of Death: 5:31 am

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-2655 ~~216-07-2655~~

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): APR.27, 1918

9. Birthplace (State or Foreign Country): RUSSIA

Usual Residance of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3216 HATTON ROAD

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GROCER

16b. Kind of Business/Industry: FOODS

17. Father's Name (First, Middle, Last): DAVID DOGOLOFF

18. Mother's Name (First, Middle, Maiden Surname): ROSE HOFF

19a. Informant's Name/Relationship (Type, Print): DORIS DOGOLOFF (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3216 HATTON RD, BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): BETH TFILOH

Data: 1-5-97

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEART BLOCK

Due to (or as a consequence of):

b. SEPSIS, LACTIC ACIDOSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPOTENSION

Due to (or as a consequence of):

d. CONGESTIVE HEART FAILURE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STROKE

DIABETES

SEIZURES

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residance 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mircea Todor, MD

29c. License number: AS 2402321 - MT 9004

29d. Data signed (Month, Day, Year): JANUARY 04 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIRCEA TODOR SINAI HOSPITAL OF BALTIMORE, 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215

State Registrar

31. Data filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Lidia Baldson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00116

Physician /Medical Examiner

1. Decadant's Nama (First, Middla, Last): Rodney Lee Dunford
2. Data of Death — Month: January Day: 1 Yaar: 1997
3. Tima of Deeth: 9:00 PM
4a. Facility Nama (If not institution, giva street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Daath: None

Funeral Director

5. Social Security Number: 214-78-9027
6. Sax: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 36 Yrs.
If Under 1 Yaar — Months: Deys:
If Under 24 Hrs. — Hours: Min.:
8. Data of Birth (Month, Dey, Yaar): Oct. 20, 1960
9. Birthpleca (Stata or Foreign Country): Maryland

Usual Residance of Decedant

10a. Stata: Md
10b. County: None
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Straet and Number: 301 Birkwood Pl.
10f. Zip Coda: 21218
10g. Citizan of What Country?: USA

11. Maritel Stetus: 1 [X] Naver Married 2 [ ] Married 3 [ ] Widowad 4 [ ] Divorcad
12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [ ] No If Yas, Giva Yaer or Detas:
13. Wes Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: Black

15. Dacadant's Education (Spacify only highest greda completed) — Elementary/Secondary (0-12): 12th; Collega (1-4or 5+): 0
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Switchboard Operator
16b. Kind of Businass/Industry: Retail / Store

17. Fether's Nama (First, Middla, Last): Robert Dunford
18. Mothar's Name (First, Middla, Meidan Surnama): Mary Jennings

19a. Informant's Name/Raiationship (Type, Print): Wanda Ford - Sister
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1637 Ralworth Rd. Baltimore, Md. 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramovel from Stata 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Mt. Zion Cemetery
Data: 01/06/97
20c. Location - City or Town, Stata: Landsdowne, Md.

21. Signatura of Funaral Servica Licensaa: Derrick C. Jones
22. Nama and Addrass of Facility: Derrick C. Jones Funeral Home 4611 Park Heights Ave. Baltimore, Md. 21215

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Batween Onset and Death

Immediata Causa (Finel diseasa or condition rasulting in daath)
e. Sepsis — 16 hours
Due to (or as a consequanca of):
b. Neutropenia — 1 year
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last
Dua to (or as a consequanca of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.
HIV / AIDS
Lymphoma

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings availabla prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No
25. Was casa rafarrad to medical examinar? 1 [ ] Yes 2 [X] No
26. Placa of Death (Check only one): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be determinad
28a. Data of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurrad
28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurrad at tha tima, data and placa, and due to tha causa(s) and manner stated.
29b. Signatura and titla of certifiar: Ileen Y. Herrero-Szotak, MD
29c. Licansa number: AT 243946
29d. Data signed (Month, Dey, Yaar): January 1, 1997
30. Nama and eddrass of parson who completed causa of daath (Item 23a) (Type, Print): Ileen Y. Herrero-Szotak 201 East University Parkway Baltimore, MD 21218-2895

State Registrar

31. Deta filad (Month, Day, Yaar): JAN 07 1997
32. Registrar's Signatura: Julia Harrison-Hopkins

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Elbert Dunn	January 1, 1997	10:12 p

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-22-7719	1 [X] M 2 [ ] F	74 Yrs.					June 2, 1922	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard County	Columbia	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5951 Millrace Court; C-203	21045	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		superintendent	construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Francis Dunn	May Hancock

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Evelyn M. Dunn/spouse	5951 Millrace Ct.; C-203, Columbia, MD 21045

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Baltimore Washington Crematory	1-4-97	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00535	Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1 hour
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 34613	January 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Geller, M.D., 9501 Old Annapolis Road, Ellicott City, Maryland 21042

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 07 1997	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ITEM: 2. PER DR. FILM G-743
1/10/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richmond Stuart Erdman, Sr.
2. Date of Death: Month January Day 4, 1997 Year (1996)
3. Time of Death: 2:15am
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-44-3785
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 17, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: N/A
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7803 Oakdale Avenue
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Patrolman
16b. Kind of Business/Industry: Baltimore City Police Department
17. Father's Name (First, Middle, Last): Howard Crosby Erdman, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Jennie Richmond
19a. Informant's Name/Relationship (Type, Print): Dale Mitchell Erdman/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7803 Oakdale Avenue, Baltimore, MD 21234
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: 1997 Jan 07
20c. Location - City or Town, State: Parkville, Maryland
21. Signature of Funeral Service Licensee: Bryan W. Clary
Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Asphyxia — minutes
Due to (or as a consequence of): aspiration pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Influenza — days
Due to (or as a consequence of):
c. History of intestinal obstruction — years
Due to (or as a consequence of):
d. ASCVD — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gerald Maggid, M.D.
29c. License number: D06973
29d. Date signed (Month, Day, Year): January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gerald Maggid, MD 8100 Harford Road, Baltimore MD 21234

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

JA

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00119

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sr. M. Alphonsa Ensor, R.S.M
2. Date of Death — Month: 1 Day: 4 Year: 97
3. Time of Death: 9 ~~50~~ AM
4a. Facility Name *(If not institution, give street and number)*: The Villa 6806 Bellona Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-54-2152
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 97 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 3-26-1899
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6806 Bellona Ave.
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Religious Sister
16b. Kind of Business/Industry: Religion
17. Father's Name *(First, Middle, Last)*: John B. Ensor
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Sparks
19a. Interment's Name/Relationship *(Type, Print)*: The Sisters of Mercy
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 11448 Baltimore, MD. 21202
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Woodlawn Cem.
Date: 1/7/97
20c. Location - City or Town, State: Woodlawn, MD.
21. Signature of Funeral Service Licensee: Edna A. Ryndak
22. Name and Address of Facility: Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto., MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. bilateral pneumonia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marie A. Dobaja
29c. License number: D29923
29d. Date signed *(Month, Day, Year)*: 1/6/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2822 Hollins Ferry Road Baltimore Md. 21230

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760 Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00120

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William E. Fisher
2. Date of Death Month/Day/Year: 01 04 1997
3. Time of Death: 5:~~5~~ ~~PM~~ AM
4a. Facility Name (If not institution, give street and number): Independent Dialysis Foundation
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 055-01-1780
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06 08 1917
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2441 Keyworth Ave.
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown | College (1-4or 5+):
16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sanitation Worker
16b. Kind of Business/Industry: Sanitation Worker

17. Father's Name (First, Middle, Last): Edward Fisher
18. Mother's Name (First, Middle, Maiden Surname): Laura (Unknown)

19a. Informant's Name/Relationship (Type, Print): Odessa Fisher (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2441 Keyworth Ave. Balto. Md. 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery | Date: 1/8/97
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Dennis B. Caple
22. Name end Address of Facility: Caple Funeral Service 5502 Winner Ave. Balto. Md. 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on aach line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseasa or condition resulting in death) a.	Myocardial Infarction	
Due to (or as a consequence of): b.	Coronary Artery Disease	2/1993
Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last — Due to (or as a consequence of): c.	Diabetes Mellitus II	1/1980
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia
Severe Vertebrobasilar Insufficiency

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☒ Other (Specify) Dialysis Unit
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be datarmined
28a. Date of Injury (Month, Day, Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledga, death occurred at tha time, date and placa, and due to the cause(a) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.
29b. Signature and title of certifier: Paul D. Light MD
29c. License number: D-17522
29d. Date signed (Month, Day, Year): 1/6/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul D. Light MD Mercy Hospital N3W143 225 Greene St. Baltimore, MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00121

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Glen Gilliam
2. Date of Death Month Day Year: January 1, 1997
3. Time of Death: 6:50 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-07-9220
8. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUN 4 1913
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedant

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2610 YORKWAY
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CRANE OPERATOR
16b. Kind of Business/Industry: STEEL COMPANY

17. Father's Name (First, Middle, Last): LEONARD GILLIAM
18. Mother's Name (First, Middle, Maiden Surname): NANNIE SALYER

19a. Informant's Name/Relationship (Type, Print): VIRGINIA C. GILLIAM
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2610 YORKWAY DUNDALK, MD. 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATORY
Date: 1/6/97
20c. Location - City or Town, State: BELTSVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BRADLEY ASHTON FUNERAL HOME, INC 2134 WILLOW SPRING RD. DUNDALK, MD. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Left emphyema

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: 96003
29d. Date signed (Month, Day, Year): January 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Durbin
Johns Hopkins Bayview MedicaL Center 4940 Eastern Avenue, Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 2 and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0010-510
CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00122

Item: 23 part II, per MEO G-744 2/26/97 rel

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
EARL	GODSDEN	JANUARY 01, 1997	0830AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4600 BLOCK GARRISON BOULEVARD	BALTIMORE CITY	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
250-48-6417	1☒M 2☐F	63 Yrs.					July 29, 1933	S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4104 Ridgewood	21215	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade	NA	Self	Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Gadsden	Pearl Murray

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gertrude Gamble - Sister	4104 Ridgewood Avenue Balto, Md 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King Memorial Park	1-6-97	Randallstown, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gala March	March F.H. West 4300 Wabash Avenue Balto, Md

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MENTAL ILLNESS

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residance 6☒Other (Specify) ROADWAY

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☑Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	1-1-97	825 AM	1☐Yes 2☑No	pedestrian struck by a car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
street	4600 Blk Garrison Blvd Baltimore, Md

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chute MD	O.C.M.E.	JANUARY 02, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 07 1997	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAURA LOUISE GROSS
2. Date of Death (Month, Day, Year): January 4, 1997
3. Time of Death: 7:45 am
4a. Facility Name (If not institution, give street and number): 501 N. Shamrock Avenue
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 390-44-8426
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 30, 1945
9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 501 N. Shamrock Avenue
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elementary School Teacher
16b. Kind of Business/Industry: Harford County Schools

17. Father's Name (First, Middle, Last): Laverne Witt
18. Mother's Name (First, Middle, Maiden Surname): Blossom LaChappelle

19a. Informant's Name/Relationship (Type, Print): Robert A. Gross (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 N. Shamrock Avenue, Bel Air, MD. 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens
Date: 1/11/97
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, INc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Day, Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: MD 18320
29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Fetting MD Johns Hopkins Oncology Center Baltimore MD 21287.

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Julia Davidson-Ringsdell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00124

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude Gillespie

2. Date of Death Month: January Day: 4 Year: 1997

3. Time of Death: 6:55 P.M.

4a. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 206-36-9136

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Nov. 7, 1906

9. Birthplece *(Stete or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Insida City Limits: 1☐ Yas ☒ No

10e. Street and Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Merriad 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Wes Decedent of Hispanic Origin? (Specity Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT usa ratirad)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Thomas B. Kelly

18. Mother's Neme *(First, Middle, Maidan Sumeme)*: Julia Welsh

19a. Informent's Neme/Reletionship *(Type, Print)*: Cliff Gillespie (Son)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 15 Brookstone Court Lutherville, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Holy Sepulchie Cemetery

Dete: Jan. 8, 1997

20c. Location - City or Town, Stete: Cheltenham, Pennsylvania

21. Signature of Funeral Servica Licansee: R. Ga. Witzke

22. Nama and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, Maryland 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicatiops that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceusa (Final disease or condition resulting in deeth)

e. DEMENTIA — 4 YEARS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Pert fl. **Other sfgnificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Plece of Deeth *(Check only one)*: Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner as stated. 2☐ **Medicat Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and dua to the cause(s) end manner steted.

29b. Signature and title of certifier: Matt V. Nunn

29c. License number: D44748

29d. Date signed *(Month, Dey, Year)*: 1/6/97 JAN. 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 07 1997

32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00125

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel Goldscher

2. Date of Death Month Day Year: January 3 1997

3. Time of Death: 11:00pm

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-12-4326

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): JAN. 6, 1907

9. Birthplace (State or Foreign Country): POLAND

Usual Residance of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: XX ☑ Yes 2 ☐ No

10e. Street and Number: 2713 C JENNER DRIVE

10f. Zip Coda: 21209

10g. Citizen of What Country?: USA

11. Meritai Status: 1 XX Never Merriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: WWII

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yas 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedant's Education (Specify only highest grade completed)

Elamantary/Secondary (0-12): 9

Coliega (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MUSICIAN

16b. Kind of Business/Industry: MUSIC

17. Fathar's Nama (First, Middle, Last): JACOB GOLDSCHER

18. Mothar's Nama (First, Middle, Maiden Surname): ANNA AUSTERLITZ

19a. Informant's Name/Ralationship (Type, Print): ISADORE GOLDSCHER (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 COBBLER CT; BALTIMORE, MD 21208

20a. Method of Disposition: 1 XX Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ADATH ISRAEL

Data: 1-5-97

20c. Location - City or Town, Stete: BALTIMORE, MD

21. Signatura of Funaral Service Licensee: Joel D Jewres

22. Nama and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Pneumonia

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseasa or Injury that initiated evants resulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☑ No

25. Was casa raferred to medical examinar? 1 ☐ Yes 2 ☑ No

28. Placa of Daath (Check only one)

Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA

Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify)

27. Manner of Daath: 1 ☑ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding Invastigation 6 ☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specity)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1 ☑ **Certifying Physician**: To the bast of my knowledge, daath occurred at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Chimene L Libaudais

29c. Licansa number: AS2402321 CL 9010

29d. Data signed (Month, Day, Year): January 3 1997

30. Name and address of person who compiated causa of daath (Item 23a) (Type, Print): Chimene L Libaudais MD Sinai Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert H. Harper

2. Date of Death: Month January Day 5 Year 1997

3. Time of Death: 12:45 A.M.

4a. Facility Name (If not institution, give street and number): 5603 Bangert Street

4b. City, Town, or Location of Death: White Marsh

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 233-52-3644

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1936

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: White Marsh

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5603 Bangert Street

10f. Zip Code: 21162

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Foreman

16b. Kind of Business/Industry: Steel Company

17. Father's Name (First, Middle, Last): Wirt Harper

18. Mother's Name (First, Middle, Maiden Surname): Stella Simmons

19a. Interment's Name/Relationship (Type, Print): Helen Harper (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5603 Bangert Street, White Marsh, MD 21162

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens Of Faith Cem.

Date: 1/7/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Esophageal Cancer — Approximate Interval: 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D30529

29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL CELANO, MD 6509 N. Charles ST, BALTIMORE, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SOMYA CHRISTOPHER HANSEN

2. Date of Death (Month, Day, Year): Jan. 3 1997

3. Time of Death: 9:24 a.m.

4a. Facility Name (If not institution, give street and number): 8314 Silver Trumpet Drive

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-02-6934

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 30 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-24-66

9. Birthplace (State or Foreign Country): Thailand

Usual Residence of Decedent

10a. State: MD.

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8314 Silver Trumpet Drive

10f. Zip Code: 21045

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Desert Storm

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian Thai

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bartender

16b. Kind of Business/Industry: Bar

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): Tongpun Anuan

19a. Informant's Name/Relationship (Type, Print): Donna Savory wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8314 Silver Trumpet Drive, Columbia, Md. 21045

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.

Date: 1/4/97

20c. Location - City or Town, State: Beltsville, MD.

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmer

22. Name and Address of Facility: WITZKE FUNERAL HOMES, INC. 5555 Twin Knolls Rd., Columbia, MD. 21045

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic renal cell Carcinoma — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: N/A

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ CR Taylor M.D.

29c. License number: D 41139

29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11065 Little Patuxent Parkway, Columbia Md, 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randolph

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vuong Hua

2. Date of Death: Month January Day 1 Year 1997

3. Time of Death: 5:15 A.M.

4a. Facility Name (If not institution, give street and number): 5523 Cedar Lane

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-33-3866

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/31/1921

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: MD. | 10b. County: Howard | 10c. City, Town or Location: Columbia | 10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5523 Cedar Lane | 10f. Zip Code: 21044 | 10g. Citizen of What Country? China

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Chinese

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): shoe maker

16b. Kind of Business/Industry: own business

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Hue Quoc Hua (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5523 Cedar Lane, Columbia, Md. 21044

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc. | Date: 1/3/97

20c. Location - City or Town, State: Beltsville, Md

21. Signature of Funeral Service Licensee: ▶ Handa L Lemmer

22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, Md. 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 2 months;
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: N/A

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? N/A 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [illegible] MD

29c. License number: D41139

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11065 Little Patuxent Pkwy Columbia, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00129

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): O'Neal C. Herron
2. Deta of Deeth — Month: 01 Dey: 05 Year: 97
3. Time of Death: 11:42 AM
4a. Facility Neme (If not institution, giva street and number): 4800 Yellow Wood Ave Apt. 407
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 247-44-6760
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Yaar — Months: Deys:
If Under 24 Hrs. — Hours: Min.:
8. Dete of Birth (Month, Day, Year): 7-31-25
9. Birthpiece (State or Foreign Country): S.C

Usual Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4800 Yellow Wood Avenue APT 407
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+): 2
18a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Hospital

17. Fether's Neme (First, Middle, Last): Thomas Simmons
18. Mother's Neme (First, Middle, Meiden Surname): Eliza Simmons

19a. Informent's Neme/Reletionship (Type, Print): Thomas H. Hagin-Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1706 Windemere Ave Baltimore, MD 21218

20a. Method of Disposition: 1☒ Buriei 2☐ Cremetion 3☐ Removei from Stete 4☐ Donetion 5☐ Othar (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): King Memorial Park
Dete: 1-9-97
20c. Location - City or Town, Stete: Randallstown, MD

21. Signature of Funerel Service Licensee: ▶ [signature]
22. Nama and Addrass of Facility: Albert P. Wylie Funeral Home P.A. 6380 N. Gilmor Street Baltimore, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction

Due to (or as a consequence of): b. Atherosclerotic Cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Coronary Artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ CP Kearney MD
29c. License number: D27860
29d. Date signed (Month, Day, Year): January 6th 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CHRISTOPHER D. KEARNEY MD 700 WASH BLVD BALT MD

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Julia Davidson-Randall
21230

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 00130

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cecil Johnston
2. DATE OF DEATH: MONTH January DAY 5 YEAR 1997
3. TIME OF DEATH: 9:55 AM
4. SOCIAL SECURITY NUMBER: 214 14 4488
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/27/97
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: n/a

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: n/a
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2538 McCulloh Street
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Achitect
16b. KIND OF BUSINESS/INDUSTRY: Balto City Public Schools
17. FATHER'S NAME (First, Middle, Last): Arthur R. Johnston
18. MOTHER'S NAME (First, Middle, Maiden Surname): Etta
19a. INFORMANT'S NAME (Type/Print): wife — Gloria J. Johnston
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2538 McCulloh Street Baltimore, Maryland 21217
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park DATE: Jan 8
20c. LOCATION — City or Town, State: Baltimore County, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barry Li Rollini
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Non small cell lung carcinoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. lower gastrointestinal bleed
DUE TO (OR AS A CONSEQUENCE OF):
c. Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation, hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: GK-9062
29d. DATE SIGNED (Month, Day, Year): ▶ January 5, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary Kanoshige 2401 W. Belvedere Ave. Baltimore, MD 21215
31. DATE FILED (Month, Day, Year): JAN 07 1997
32. REGISTRAR'S SIGNATURE: Lia Davidson-Pandelis

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Johnson
2. Data of Death Month: January Day: 6 Year: 1997
3. Time of Death: 5:25 Am
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 222-33-3586
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 4-15-04
9. Birthplaca (State or Foreign Country): Mississippi

Usual Rasidanca of Decedant

10a. Stata: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 2801 Rayner Ave.
10f. Zip Coda: 21216
10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorcad
12. Was Dacadant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Raca - Amarican Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Laborer
18b. Kind of Businass/Industry: Construction

17. Fathar's Nama (First, Middla, Last): Unknown
18. Mother's Nema (First, Middla, Maidan Surnama): Unknown

19a. Informant's Name/Relationship (Type, Print): Tonya Roberts-Guardian
19b. Malling Address (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Coda): 861 Park Ave. Baltimore, MD 21201

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Nama of cametary, cramatory or othar placa): Mt. Zion Cemetery Data: 1/7/97
20c. Location - City or Town, Stata: Lansdowne, MD

21. Signature of Funaral Service Licensee:
22. Nama and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximata Interval Between Onset and Death

Immediate Cause (Finel disaasa or condition resulting in daath)
a. Pleural Effusion
Dua to (or as a consequence of):
b. Pneumonia
Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Ceusa (Disaasa or injury that initiated avants rasulting in daath) Last
Dua to (or as a consequance of):
c. Pulmonary Tumor
Dua to (or as a consequance of):
d. Respiratory Failure

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy parformed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of causa of daath? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medical axaminar? 1 [ ] Yas 2 [X] No
26. Placa of Death (Check only one): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residanca 6 [ ] Othar (Specify)

27. Manner of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Data of Injury (Month, Day Year)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledga, daath occurrad at the time, data and placa, and dua to tha causa(s) and manner as statad. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.
29b. Signatura and titla of certifiar: Myo Swe Chang
29c. Licansa number: 89268
29d. Data signed (Month, Day, Year): 1/6/97

30. Name and address of parson who completed causa of death (Item 23a) (Type, Print): Myo Chang, M.D. c/o Maryland General Hospital.

State Registrar

31. Data filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Franklin Kane, Jr.

2. Date of Death (Month, Day, Year): January 6, 1997

3. Time of Death: 6:55a

4a. Facility Name (If not institution, give street and number): 1809 N. Broadway

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-22-5561

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 23, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1809 N. Broadway

10f. Zip Code: 21213

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shipping Clerk

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Joseph Franklin Kane Sr.

18. Mother's Name (First, Middle, Maiden Surname): Alice E. Scurry

19a. Informant's Name/Relationship (Type, Print): Esther Kane (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1809 N. Broadway Baltimore, Md. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem Park

Date: 1/10/97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Caple Funeral Service 5502 WINNER AVENUE BALTIMORE, MD. 21215

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Multi-infarct dementia — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: M6335

29d. Date signed (Month, Day, Year): JANUARY 07, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gregory M. Lucas 600 N. Wolfe St, Baltimore

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00133

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NICHOLAS JOHN KIOUSSIS
2. Date of Death Month: January Day: 4, Year: 1997
3. Time of Death: 3:15 PM
4a. Facility Name *(If not institution, give street and number)*: 7248 Conley Street
4b. City, Town, or Location of Death: Eastwood
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220 66 2490
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11 04 58
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Eastwood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7248 Conley Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Service Technician
16b. Kind of Business/Industry: Office Furniture

17. Father's Name *(First, Middle, Last)*: Nicholas Theodore Kioussis
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Strausbaugh

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen P. Kioussis,Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7248 Conley Street Balto.,Md. 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery
Date: 1-8-96
20c. Location - City or Town, State: Glen Burnie,Md.

21. Signature of Funeral Service Licensee: Charles S. Zeiler
22. Name and Address of Facility: Charles S. Zeiler & Son Inc. 901 S. Conkling St, Balto.,Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER — 6 MONTHS

Due to (or as a consequence of):
b. BRAIN METASTASES — 6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elisabeth Iljas ONCOLOGY FELLOW
29c. License number: D0050753
29d. Date signed *(Month, Day, Year)*: January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elisabeth Iljas Johns Hopkins Oncology Center 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997
32. Registrar's Signature: Marlon-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00134

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALFRED KING

2. Date of Death Month Day Year: JANUARY 2 1997

3. Time of Death: 2200

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-80-3666

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-17-1960

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md

10b. County: Balto

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7213 Croydon Road

10f. Zip Code: 21207

10g. Citizen of What Country? U.S.A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): G.E.D | College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Driver

16b. Kind of Business/Industry: Baltimore City Public Works

17. Father's Name (First, Middle, Last): Lymon King

18. Mother's Name (First, Middle, Maiden Surname): Kelia Spencer

19a. Informant's Name/Relationship (Type, Print): Kelia King - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7213 Croydon Road Baltimore, Md 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery | Date: 1-8-97

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John Merck

22. Name and Address of Facility: Mauh-I-H. West 4300 Wabash Avenue Baltimore, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. AIDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Ravi MD

29c. License number: D37333

29d. Date signed (Month, Day, Year): JANUARY 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julie Gardner Rankin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00135

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GRACE L KYLE

2. Date of Death Month Day Yaer: JANUARY 2, 1997

3. Time of Death: 10:40 PM

4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-22-3472

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: March 6, 1906

9. Birthplaca *(State or Foraign Country)*: Pennsylvania

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 2615 Parallel Path

10f. Zip Coda: 21009

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada complatad)*: Elamentery/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Robert Kyle

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: (First Name Unknown) Duncan

19a. Informant's Name/Ralationship *(Type, Print)*: Mary King (grand-daughter)

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 2615 Parallel Path, Abingdon, MD 21009

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Green Mount Crematory

Data: 1/4/97

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funaral Service Licensaa: ▶ [signature]

22. Nama and Addrass of Facility: Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. CONGESTIVE HEART FAILURE — 1 WEEK

Due to (or as a consaquanca of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last

b.

Due to (or as a consaquanca of):

c.

Due to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.: LYMPHOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Spacify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha time, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ Jogendra P Mehta M.D

29c. Licansa number: D41410

29d. Data signed *(Month, Day, Yaar)*: January 03, 1997

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 07 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Anthony KOLAR
2. Date of Death (Month, Day, Year): January 1, 1997
3. Time of Death: 4:30 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-7007
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 6, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9408 Dana Vista Road
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Engineer Technician
16b. Kind of Business/Industry: Gas & Electric Co.

17. Father's Name (First, Middle, Last): Thomas Kolar
18. Mother's Name (First, Middle, Maiden Surname): Josephine Persain

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary Kolar (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9408 Dana Vista Road, Baltimore, MD 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.
Date: 1/4/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mattie Dent
22. Name and Address of Facility: Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): e. Congestive Heart Failure — 5 Days

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Ischemic Cardiomyopathy

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other signifícant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

Chronic Obstructive Pulmonary Disease

Pre-Renal Azotemia

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveliable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David B. Peichert MD
29c. License number: D31008
29d. Date signed (Month, Day, Year): January 2.1997

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): David Peichert MD. 9000 Franklin Square Dr. Balto, Md. 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: ▶ Gina Davidson-Gordon

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00137

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE KEMPLER
2. Date of Death (Month, Day, Year): JANUARY 3, 1997
3. Time of Death: 3:50 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-16-9954
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 27, 1918
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6819 FAIRLAWN AVE.
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES
18b. Kind of Business/Industry: WHOLESALE

17. Father's Name (First, Middle, Last): JOSEPH KEMPLER
18. Mother's Name (First, Middle, Maiden Surname): SARAH RICE

19a. Informant's Name/Relationship (Type, Print): MRS. ROSE LEE KEMPLER (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6819 FAIRLAWN RD. BALTIMORE, MD 21215

20a. Method of Disposition: XX Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RODFE ZEDEK | Date: 1/5/97
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. END STAGE RENAL DISEASE	1 YEAR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA; DIABETIS MELLITUS; HYPERTENSION; STATUS POST PACEMAKER SECONDARY TO SICK SINUS SYNDROME

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D18502
29d. Date signed (Month, Day, Year): JANUARY 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ORLANDO B. GONAHAN MD NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00138

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GILES W. KINNER

2. Date of Death — Month: JAN; Day: 4; Year: 97

3. Time of Death: 10:10 p.m.

4a. Facility Name *(If not institution, give street and number)*: SALISBURY CENTER/GENESIS ELDER CARE

4b. City, Town, or Location of Death: SALISBURY, MD

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 577 09 3169

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jun 20 1913

9. Birthplace *(State or Foreign Country)*: Pa.

Usual Residence of Decedent

10a. State: Md

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1526 E. Sharon Drive

10f. Zip Code: 21804

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrical

16b. Kind of Business/Industry: Kinner Electric

17. Father's Name *(First, Middle, Last)*: Joseph Henry Kinner

18. Mother's Name *(First, Middle, Maiden Surname)*: Sibil English

19a. Informant's Name/Relationship *(Type, Print)*: Giles W. Kinner Jr.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1711 Shady Side Dr., Edgewater, Md 21037

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft Lincoln Cemetery

Date: Jan 8 1997

20c. Location - City or Town, State: Brentwood Md

21. Signature of Funeral Service Licensee: Chas J Boarman

22. Name and Address of Facility: Hardesty Funeral Home, P.A., 905 Galesville Rd., Galesville, Md20654

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COPD — Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? ☒ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes ☒ 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes ☒ 2 No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: ☒ 4 Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald P. Trawitz MD

29c. License number: D36576

29d. Date signed *(Month, Day, Year)*: 1/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RONALD P. TRAWITZ MD SALISBURY MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: L. Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Marie KING

2. Date of Death (Month, Day, Year): January 5, 1997

3. Time of Death: 12:15 Am

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: N/A

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-09-7329

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09-04-1913

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8800 WALTHER BLVD.

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DEPT. MANAGER HECHT CO.

16b. Kind of Business/Industry: WRAPPING DEPT.

17. Father's Name (First, Middle, Last): FRANK E. DITMAN

18. Mother's Name (First, Middle, Maiden Surname): ELLA MAE SMELTZER

19a. Informant's Name/Relationship (Type, Print): MARY R. GRANT (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6515 LEWIS RD. BALDWIN, MD. 21013.

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEM.

Date: 01/08/1997

20c. Location - City or Town, Stete: PARKVILLE, MD.

21. Signature of Funerel Servica Licensee: William R. Jarvis III

22. Name end Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approxtmate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarction — 4 wks

Due to (or as a consequence of): CAD — years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: R. Magno MD

29c. License number: D09350

29d. Date signed (Month, Dey, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMUNDO MAGNO M.D. 7811 WISE AVE. BALTO., MD. 21222.

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00140

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennie Kilbourne

2. Date of Death (Month, Day, Year): January 1, 1997

3. Time of Death: 9:30 a.m.

4a. Facility Name (If not institution, give street and number): Fairhaven Nursing Home

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 215-07-2746

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 17, 1902

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll County

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7200 Third Avenue

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): sales clerk

18b. Kind of Business/Industry: department store

17. Father's Name (First, Middle, Last): William C. Fulton

18. Mother's Name (First, Middle, Maiden Surname): Emma C. (unknown)

19a. Informant's Name/Relationship (Type, Print): Mr. Edgar Kilbourne/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4622 Doncaster Drive, Ellicott City, Maryland 21043

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crematory

Date: 1-3-97

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIAC ARRHYTHMIA — 10 minutes

Due to (or as a consequence of):
b. HYPERKALEMIA — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D22220

29d. Date signed (Month, Day, Year): January 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ellis Mez MD 1645 Liberty Rd. Eldersburg, MD. 21784

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Jutta Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0041-510
B.K.S

ITEMS· 23 PART I, 27, 28a-f
PER MEO FILM g-743 1/30/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PRESTON LITTLE
2. Date of Death Month JAN. Day 3, Year 1997
3. Time of Death 8:07AM
4a. Facility Name (If not institution, give street and number): 4100 FAIRVIEW ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 214-56-9637
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-20-52
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 4100 Forest Park Avenue
10f. Zip Code: 21207
10g. Citizan of What Country?: USA

11. Maritai Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedent Ever In U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grada completad)
Elementery/Secondary (0-12): 12
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Painter
16b. Kind of Business/Industry: Home Improvement

17. Father's Name (First, Middla, Last): Preston Little SR.
18. Mother's Name (First, Middle, Maiden Surname): AlFredia Gale

19a. Informant's Name/Ralationship (Type, Print): Gregory Hardy
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda): 963 Ellicott Drive Way Baltimore, MD 21216

20a. Methoa of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cematery, crematory or othar place): MT Zion
Data: 1-8-97
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: ▶
22. Nama and Address of Facility: Albert P. Wylie Funeral Home P.A. ~~330~~ N. Gilmor Street Baltimore, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. COCAINE INTOXICATION
Due to (or as e consequence of):
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated avents resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco uss contributa to the causs of death? 1 [ ] Yss 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings availabla prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was cese referred to medical examiner? [X] Yes 2 [ ] No
26. Piece of Deeth (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify)
27. Menner of Deeth: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year): 1-3-97 FOUND
28b. Time of Injury: FOUND 7:00 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT INGESTED DRUGS
28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify): FOUND AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, Stata): 4100 FAIRVIEW AVE. BALTIMORE, MD.

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Stephen S. Radentz, MD
29c. Licansa number: O.C.M.E
29d. Data signed (Month, Day, Year): JAN. 3, 1997
30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TEDDY LAMBROW

2. Date of Death (Month, Day, Year): January 5, 1997

3. Time of Death: 7:00 A.M.

4a. Facility Name (If not institution, give street and number): 453 N. Bouldin Street

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 234-10-0697

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 26, 1916

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 453 N. Bouldin Street

10f. Zip Code: 21224

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No. If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Proprietor

16b. Kind of Business/Industry: Bakery

17. Father's Name (First, Middle, Last): Konstantine Lambrow

18. Mother's Name (First, Middle, Maiden Surname): Stergoula Catherine Pazakis

19a. Informant's Name/Relationship (Type, Print): Mrs. Dorothy Lambrow, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 453 N. Bouldin Street, Baltimore, Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 1-8-97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Ann S. Matthews

22. Name and Address of Facility: Matthews Funeral Home, 3021 Eastern Ave., Baltimore, Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cancer of the prostate with bone metastasis — > 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Melito M. Torres

29c. License number: D11150

29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00143

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henry A. Montague Jr.

2. Date of Death — Month: 01 Day: 04 Year: 97

3. Time of Death: 4:36 am

4a. Facility Name *(If not institution, give street and number)*: University of Maryland Med System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-28-6097

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 14, 1933

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residance of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 305 East Joppa Road

10f. Zip Code: 21286

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [ ] Married 3 [ ] Widowad 4 [X] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaar or Datas: 1954-57

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* black

15. Dacedant's Educetion *(Spacify only highast grada complated)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+): 1

16e. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: mechanic

16b. Kind of Businass/Industry: automobile

17. Fathar's Nama *(First, Middla, Last)*: Henry Arthur Montague Sr.

18. Mother's Nama *(First, Middla, Maidan Surnema)*: Lillie Montague Anderson

19a. Informant's Nama/Ralationship *(Type, Print)*: Sabrina Montague/daughter

19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 10365 College Square, Columbia, Maryland 21044

20a. Mathod of Disposition: 1 [ ] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [X] Donation 5 [ ] Othar *(Spacify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or othar place)*

Data

20c. Location - Cify or Town, Stata

21. Signatura of Funaral Service Licensea: ▶ Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that ceused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Between Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Cardiac and Respiratory arrest — 20 min

Due to (or as a consequence of):

b. Coronary artery disease

Sequentially list conditions, if any, laading to immediata ceusa. Entar Underlying Causa (Diseasa or injury that initiated evants rasulting in daath) Last

Due to (or as a consaquance of):

c. Metabolic acidosis, Sepsis

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [✓] No

24b. Wara autopsy findings available prior to complation of ceusa of death? 1 [ ] Yas 2 [ ] No

25. Was cesa rafarred to medical examinar? 1 [ ] Yas 2 [✓] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [✓] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Daath: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Sulcida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledga, daath occurrad at tha time, data and placa, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examinar:** On tha basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Vad. Sidorov M.D.

29c. License number: 8594

29d. Data signed *(Month, Day, Year)*: 01/04/96

30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print): Vad Sidorov M.D. UMMS, surgery Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene Ethel Maurath

2. Date of Death: Month Jan. Day 02, Year 1997

3. Time of Death: 6:45 AM

4a. Facility Name (If not institution, give street and number): 22 Lochmoor Ct.

4b. City, Town, or Location of Death: LUTHERVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-22-2247

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 2, 1902

9. Birthplace (State or Foreign Country): BALTIMORE

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: LUTHERVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 22 Lochmoor Ct.

10f. Zip Code: 21093

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Daniel Michel

18. Mother's Name (First, Middle, Maiden Surname): Anna Kucherer

19a. Informant's Name/Relationship (Type, Print): Son Mr. Wilbur M.L. Maurath,Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 Lochmoor Ct., Lutherville, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 6 JAN 1997

20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. T. Souweine MD

29c. License number: 024732

29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): E. T. Souweine MD 515 Fairmount Ave Towson MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00145

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Blake MURPHY

2. Date of Death Month Day Year: January 4 1997

3. Time of Death: 1:30 a.m.

4a. Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 066 12 9093

6. Sex: ☒ 1 M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 14, 1921

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 12310 Manvel Lane

10f. Zip Code: 20715

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Personnel

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Robert B. Murphy

18. Mother's Name (First, Middle, Maiden Surname): Margaret Ruper

19a. Informant's Name/Relationship (Type, Print): Miriam B. Murphy Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12310 Manvel Lane Bowie Maryland 20715

20a. Method of Disposition: XX 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Maryland Veterans Cemetery

Date: 1/10/97

20c. Location - City or Town, State: Cheltenham Md.

21. Signature of Funeral Service Licensee: Robert E. Evans Pres

22. Name and Address of Facility: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval: 2 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- End stage liver Cirrhosis
- Coronary artery disease
- Esophageal Varices

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Riad Dakheel M.D

29c. License number: D26492

29d. Date signed (Month, Day, Year): 1/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Riad Dakheel M.D. 4000 Mitchellville Rd. Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

154

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene H. Murphy
2. Date of Death: Month: January; Day: 1; Year: 1997
3. Time of Death: 1:27 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-03-2923
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 23, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4324 Parkside Drive
10f. Zip Code: 21206
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: Western Electric

17. Father's Name (First, Middle, Last): William F. Murphy
18. Mother's Name (First, Middle, Maiden Surname): Carrie E. Harvey

19a. Informant's Name/Relationship (Type, Print): Douglas C. Murphy (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3606 Crossland Avenue, Baltimore, Maryland 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. Date: 1/4/1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial infarction	1 day
Due to (or as a consequence of):	b. Urosepsis	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pneumonia	1 day
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease, Parkinson's disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Durbin, MD
29c. License number: 96003
29d. Date signed (Month, Day, Year): January 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Durbin 4940 Eastern Avenue Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

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FILM g-743 1/30/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES RICHARD NALE
2. Date of Death Month Dey Year: JAN.03,1997
3. Time of Death: 1445 P
4a. Facility Neme *(If not institution, give street end number)*: 200 BELLE HILL RD. RM.216
4b. City, Town, or Location of Death: Elkton
4c. County of Deeth: CECIL

Funeral Director

5. Social Security Number: 441-41-3317
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 50 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: September 11,1946
9. Birthplace *(Stete or Foreign Country)*: Oklahoma

Usuel Residence of Decedent

10a. Stete: OK
10b. County: Tulsa
10c. City, Town or Location: Tulsa
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 429 S. 66th E. Avenue
10f. Zip Code: 74112
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Detes: Vietnam
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Edeetion *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Freight

17. Fether's Name *(First, Middle, Last)*: Mickey Nale
18. Mother's Name *(First, Middle, Meiden Surneme)*: Alma unknown

19a. Informant's Neme/Reletionship *(Type, Print)*: Judy Nale, wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 429 S. 66th E. Avenue, Tulsa, OK 74112

20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Crematory, Inc. — Date: 1/06/97
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Steven Hutteman
22. Name end Address of Feeility: Gary L. Kaufman Funeral Homes 7250 Washington Blvd. Elkridge, MD 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as e consequence of):
Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest: b. Due to (or es a consequence of): c. Due to (or as e consequenca of): d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en eutopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was cese referred to medicel examiner? 1☒Yes 2☐No
26. Plece of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* AT SCENE
27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☐ **Certifying Physicten:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner as stated. 2☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Marjorie Breyhill
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JAN. 04, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MARYANN B. KROLL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 07 1997
32. Registrer's Signature: Lia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00148

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SONIA Pitts
2. Date of Death Month: 1 Day: 2 Year: 97
3. Time of Death: P.M.
4a. Facility Name (If not institution, give street and number): 1344 CROFTON Rd
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N.A

Funeral Director

5. Social Security Number: 216 34 8098
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-31-39
9. Birthplace (State or Foreign Country): N.C

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md. | 10b. County: N.A. | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1344 Crofton Rd | 10f. Zip Code: 21239 | 10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): scout

16b. Kind of Business/Industry: Soc. Security Adm

17. Father's Name (First, Middle, Last): Wilbert Stewart

18. Mother's Name (First, Middle, Maiden Surname): MABLE Brooks

19a. Informant's Name/Relationship (Type, Print): Johnson Pitts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1344 Crofton Rd Balto. MD 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem. | Date: 1/7/97

20c. Location - City or Town, State: LANDSDOWNE. MD

21. Signature of Funeral Service Licensee: Joseph B. Locke Jr

22. Name and Address of Facility: Locke Funeral Home 1304 N. Central Ave

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ESOPHAGEAL CANCER — 8 MONTHS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SPONTANEOUS PNEUMOTHORAX

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel Keimig MD | 29c. License number: D23855 | 29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL KEIMIG, MD. 5820 York Rd Balt., MD 21212

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00149

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT P. POISALL

2. Data of Death Month / Day / Year: JANUARY 3 1997

3. Time of Death: 4:35 PM

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 344-12-4119

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 05/16/1926

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residance of Decedant

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1445 N. Rolling Rd.

10f. Zip Coda: 21228

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Rece - American Indian, Black, Whita, etc. Specify: White

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Real Estate Investor

16b. Kind of Businass/Industry: Real Estate

17. Fathar's Nama *(First, Middle, Last)*: Robert Charles Poisall

18. Mothar's Nama *(First, Middla, Maidan Surname)*: Vivian R. McCullough

19a. Informent's Name/Ralationship *(Type, Print)*: Margaret M. Poisall/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1445 N. Rolling Rd. Catonsville, MD. 21228

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Data: 1/6/97

20c. Location - City or Town, Stata: Beltsville, MD.

21. Signature of Funeral Service Licensee: Edward A. Sterling

22. Nama and Address of Facility: Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto., MD. 21228

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on aach lina.

Approximata Intarval Between Onset and Death

Immedieta Causa (Final disaasa or condition rasulting in death)

e. BILATERAL PNEUMONIA — Approximata Intarval Between Onset and Death: 1-WEEK

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immedieta cause. Entar Underlying Cause (Disaase or Injury that initiated events rasulting in daath) Last

b. Dua to (or as a consequance of):

c. Dua to (or as a consequance of):

d. Dua to (or as a consequance of):

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

OLD MYOCARDIAL INFARCTION

THROMBOCYTOPENIA

PAROXYSMAL ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, date and place, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: MD.

29c. Licansa number: D19502

29d. Data signed *(Month, Day, Year)*: JANUARY 3 1997

30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print): ORLANDO B. CONAWAY MD — NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD. 21133

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit — pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00150

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Madelyn PURCELL
2. Date of Death Month Day Year: January 03, 1997
3. Time of Death: 6:35P
4a. Facility Name *(If not Institution, give street and number)*: Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-05-9607
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 31, 1915
9. Birthplace *(State or Foreign Country)*: Massachusettes

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12613 Quoting Poet Court
10f. Zip Code: 20720
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Program Analyst
16b. Kind of Business/Industry: Department of Army

17. Father's Name *(First, Middle, Last)*: Louis Robinson
18. Mother's Name *(First, Middle, Maiden Surname)*: Madelyn McGilvray

19a. Informant's Name/Relationship *(Type, Print)*: Janice F. Wade Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12613 Quoting Poet Court Bowie Maryland 20720

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: 1/7/97
20c. Location - City or Town, State: Clinton Maryland

21. Signature of Funeral Service Licensee: ▶ Robert E. Evans Pres.
22. Name and Address of Facility: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. multilobar Pneumonia — 4 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Riad DaKheel m.D.
29c. License number: D 26492
29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Riad DaKheel m.D 4000 Mitchellville Rd, Bowie, MD 20716

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997
32. Registrar's Signature: ▶ L. Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 5 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

97-0025-023
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00151

ITEM; 20, per F.H. G-743 1/7/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Last): WILLIAM PAWLIKOWSKI
2. Dete of Death Month JAN. Day 1, Yaer 1997
3. Time of Death: 1330 PM
4e. Facility Name (If not institution, give street end number): 1 MILE WEST OF ROUTE#495
4b. City, Town, or Location of Daath: BITTINGER
4c. County of Deeth: GARRETT

Funeral Director

5. Social Security Number: 202-48-5307
6. Sax 1☒M 2☐F
7. Aga (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Dey, Year): 03-20-1960
9. Birthplace (State or Foraign Country): PENNSYLVANIA

Usual Residence of Decedent

10e. Stete: PA.
10b. County: WESTMORELAND
10c. City, Town or Location: MT. PLEASANT TOWNSHIP
10d. Inside City Limits 1☐Yes 2☒No
10e. Street and Number: R.D. #2 BOX535 MT. PLEASANT
10f. Zip Code: 15666
10g. Citizan of Whet Country?: U.S.a
11. Marital Status 1☐Naver Married 2☐Married 3☐Widowed 4☒Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐Yas 2☒No If Yes, Give Year or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - Amarican Indian, Bieck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest greda completed) Elementery/Secondary (0-12): 12YRS. College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): PLUMBER
16b. Kind of Business/Industry: PLUMBING
17. Fethar's Name (First, Middle, Last): EUGENE PAWLIKOWSKI
18. Mother's Neme (First, Middle, Meiden Surname): MARY JANE QUINN
19a. Informent's Neme/Relationship (Type, Print): EUGENE PAWLIKOWSKI
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 25 HIGH ST. MT. PLEASANT,PA. 15666.
20a. Method of Disposition 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): MOUNT JOY CEMETERY ~~TRANSFIGURATION~~ Date: 01/06/97
20c. Location - City or Town, State: MT. PLEASANT,PA.
21. Signature of Funerel Sarvice Licensee: William R. Jones III
22. Neme end Address of Fecility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onsat and Death

Immediete Cause (Finel diseese or condition resulting in death): a. Multiple Injuries
Due to (or es a consequence of):
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceusa (Disease or Injury thet Initiated events resulting in death) Last:
b. Due to (or es e consequence of):
c. Due to (or es a consequence of):
d.

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? ~~1☒~~Yes 2☐No

24b. Were autopsy findings available prior to complation of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medicel examiner? ☒Yes 2☐No

26. Place of Deeth (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) FIELD

27. Manner of Death 1☐Natural 2☒Accident 3☐Suicida 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Year): 1-1-97
28b. Time of Injury: 1308 P M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: airplane crash
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify): Field
28f. Location (Street end Number or Rural Route Number, City or Town, State): 1 mile west of Rt 495 Bittinger, Md

29a. Certifier (Check only one) 1☐**Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. ☒**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: Dennis J. Chute MD
29c. License number: O.C.M.E
29d. Dete signed (Month, Day, Year): JAN. 2, 1997

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 07 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00152

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles P. Reilly
2. Date of Death Month Day Year: Jan. 3, 1997
3. Time of Death: 7:30 P.M.
4a. Facility Name (If not institution, give street and number): 27 East Heath St.,
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-18-6953
6. Sex: X 1 M 2 F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 6, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 27 East Heath Street
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? X X Yes 2 No If Yes, Give Yaar or Dates: Navy
13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Checker
16b. Kind of Business/Industry: Longshoreman
17. Father's Name (First, Middle, Last): Allen Reilly
18. Mother's Name (First, Middle, Maiden Sumame): Alice E. Murray
19a. Informant's Name/Relationship (Type, Print): Jane Smoot/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46 E. Heath St., Baltimore, Md. 21230
20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Chesapeake Crematory
Date: 1-7-97
20c. Location - City or Town, Stata: Beltsville, Md.
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Peripheral Vascular disease	3 yrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last b.	Diabetes Mellitus	5 yrs
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauea of death? 1 X Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how Injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the bast of my knowledge, death occurred at the time, date and placa, and dua to tha cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier: MD
29c. Licensa number: D14622
29d. Data signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Herbert L. Munoz, Jr. M.D. 29 S. Paca St, Balto, Md 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signeture: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Page 1 and should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If manner of death other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR CHESTER RUSHTON

2. Date of Death: Month JANUARY Day 4 Year 1997

3. Time of Death: 11:50 AM

4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-01-5100

6. Sex: [X] 1 M [ ] 2 F

7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): FEB. 9, 1915

9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: [ ] 1 Yes [X] 2 No

10e. Street and Number: 56 DUNGARRIE ROAD

10f. Zip Code: 21228

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK

16b. Kind of Business/Industry: ALUMINIUM FABRICATORS

17. Father's Name (First, Middle, Last): ARTHUR H. RUSHTON

18. Mother's Name (First, Middle, Maiden Surname): CLARA (COOPER)

19a. Informant's Name/Relationship (Type, Print): LAURA RUSHTON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 56 DUNGARRIE RD. CATONSVILLE, MD 21228

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK MAUSOLEUM

Date: JAN. 7, 1997

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Anthony S. Dimen

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME, 3620 WILKENS AVE. BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — Minutes

Due to (or as a consequence of):
b. CAD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Diabetes

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pacemaker

Arrythmias

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [ ] 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death (Check only one): Hospital: [ ] 1 Inpatient [X] 2 ER/Outpatient [ ] 3 DOA; Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other (Specify)

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mohammad Saleem MD

29c. License number: D40610

29d. Data signed (Month, Day, Year): January 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMAD SALEEM, ST. AGNES HOSP - ER

State Registrar

31. Data filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/signed by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00154

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: EDWARD JOHN SNYDER, SR.

2. Dete of Deeth — Month: January; Dey: 4; Year: 1997

3. Time of Deeth: 04:30 AM

4e. Facility Neme *(If not institution, give street end number)*: St. Agnes Hospital

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 214-03-1938

6. Sex: 1☒M 2☐F

7. Age *(In yrs. lest birthday)*: 86 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Sept. 6, 1910

9. Birthpiece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 149 Oakley Village Apt. 149

10f. Zip Code: 21229

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 6; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: shear operator

16b. Kind of Business/Industry: sheet metal

17. Fether's Neme *(First, Middle, Lest)*: August C. Snyder

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Linzetta Swartz

19e. Informent's Neme/Relationship *(Type, Print)*: Ruby A. Snyder, wife

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 149 Oakley Village Apt. 149 Balto., MD 21229

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Crestlawn Memorial

Date: 1/7/97

20c. Location - City or Town, Stete: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Paul W. Hogan

22. Neme end Address of Feciility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or comelicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. END STAGE CONGESTIVE HEART FAILURE — 5 years

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest

b. PNEUMONIA — 12 days

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Menner of Deeth: 1☒Nature 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: Gebeyaneyh FOSSETT

29c. License number: P09137

29d. Dete signed *(Month, Dey, Yeer)*: January 4, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Gebeyaneyh FOSSETT, M.D., Saint Agnes Hospital

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 07 1997

32. Registrer's Signeture: Linda Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STELLA SCHAUB

2. Date of Death: Month January Day 4 Year 1997

3. Time of Death: 5.05 AM

4a. Facility Name (If not institution, give street and number): KESWICK, 700 WEST 40th STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 216-01-6605

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 18, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 515 North Luzerne Avenue

10f. Zip Code: 21205

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cord Inspector

18b. Kind of Business/Industry: Electric Company

17. Father's Name (First, Middle, Last): Julius Napierski

18. Mother's Name (First, Middle, Maiden Surname): Mary Anne Poitrowski

19a. Informant's Name/Relationship (Type, Print): William Schoeffield (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3211 Wisteria Avenue, Baltimore, Maryland 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.

Date: 1-7-97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration pneumonia — Approximate Interval: 6hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive cardiovascular disease. Chronic atrial fibrillation. Thrombotic Stroke, remote.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M. Isabelle MacGregor MD

29c. License number: D13657

29d. Date signed (Month, Day, Year): January 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M. ISABELLE MACGREGOR, KESWICK, 700 W. 40th STREET, BALTIMORE, MD 21211

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: ▶ Julie Davidson-Rogers

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#4c PER F.H. FILM#G743 1-7-97 J.A. *Certificate of Death*

Reg. No. 97 00156

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Fred R. Strauss
2. Dete of Deeth: Month January Dey 02 Year 1997
3. Time of Death: 4:52 PM
4e. Feciilty Neme *(If not institution, give street end number)*: Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: ~~Baltimore~~ N/A

Funeral Director

5. Social Security Number: 213-30-8947
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: SEPT. 23, 1928
9. Birthplace *(Stete or Foreign Country)*: GERMANY

Usuei Residence of Decedent

10e. Stete: MD
10b. County: BALTIMORE
10c. City, Town or Location: LUTHERVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 515 BRIGHTFIELD RD.
10f. Zip Code: 21093
10g. Citizen of Whet Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12) / Coilega (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK
16b. Kind of Busiress/Industry: SHIPPING
17. Father's Name *(First, Middle, Last)*: MYER STRAUSS
18. Mother's Name *(First, Middle, Maiden Surneme)*: JULIA FRIEDENWALD
19a. Informant's Neme/Reletionship *(Type, Print)*: MYER STRAUSS (NEPHEW)
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 42 W. 13TH ST., APT. 2-D NEW YORK, NY 10011
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removei from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: BALTIMORE HEBREW
Dete: 1/5/97
20c. Location - City or Town, Stete: BALTIMORE, MD
21. Signeture of Funerel Service Licensee: [signature]
22. Neme and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the diseese or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immedieta Ceuse (Finel disease or condition resulting in deeth): e. Hypoxic Respiratory failure

Dua to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest:

b. Anasarca & pulmonary edema

Due to (or es e consequence of):

c. Renal failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [ ] No 3 [X] **Probably** 4 [ ] **Unknown**

24a. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Piece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the beeis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end mennar steted.

29b. Signeture and title of certifier: [signature]

29c. License number: AS-240234-05-9034

29d. Dete signed *(Month, Dey, Year)*: January 02, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Sinai Hospital Danny Song, MD

State Registrar

31. Deta filed *(Month, Dey, Year)*: JAN 07 1997

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Divisian of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00157

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lewis Sears
2. Date of Death Month: Jan Day: 04 Year: 97
3. Time of Death: 1:55pm
4a. Facility Name *(If not institution, give street and number)*: Howard County General
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 227-10-0206
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5/31/1920
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4920 Wharff Lane
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WW II.
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work donie during most of working life. DO NOT use retired)*: Technical Illustrator
16b. Kind of Business/Industry: Westinghouse

17. Father's Name *(First, Middle, Last)*: Charlie E. Sears
18. Mother's Neme *(First, Middle, Melden Surname)*: Ruby Powell

19a. Informent's Neme/Relationship *(Type, Print)*: Margaret U. Sears/ Wife
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4920 Wharff Lane Ellicott City, MD 21043

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Greenlawn
Dete: 1/8/1997
20c. Location - City or Town, State: Virginia

21. Signeture of Funeral Service Licensee: Robert Gregg Burke
22. Name end Address of Facility: Witzke Funeral HOme 1630 Edmondson Ave. Catonsville, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or conditions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Sepsis — Days

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest
b. Urinary Tract Infection — Days

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigetion, in *my* opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end *menner* steted.

29b. Signeture and titie of certifier: C Young MD
29c. License number: D46193
29d. Dete signed *(Month, Dey, Year)*: Jan 04 97

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print): 9501 old Annapolis Rd, Suite 200 Ellicott City MD 21042 Cecilia Young, MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 07 1997
32. Registrer's Signeture: Lia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00158

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Annie SMITH
2. Date of Death Month Day Year: January 5, 1997
3. Time of Death: 9:35 am
4a. Facility Name *(If not Institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 227-34-5201
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9/25/1924
9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 22 Glenwood Road
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: William Ervy Edwards
16. Mother's Name *(First, Middle, Meiden Surname)*: Mary Birgie Nole
19a. Informant's Name/Relationship *(Type, Print)*: Pam Schwartz/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 Gwynn Lake Drive Baltimore, MD 21207
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Woodlawn Cemetery
Dete: 1/9/1997
20c. Location - City or Town, State: Baltimore
21. Signeture of Funeral Service Licensee: ▶ Robert [illegible]
22. Name end Address of Facility: Witzke Funeral Home 1630 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pulmonary Embolism — 15 minutes

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

b. Due to (or as a consequence ot):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Asthmatic Bronchitis; Morbid Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopay performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date ot Injury *(Month, Day Year)*
26b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
26t. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end manner stated.

29b. Signeture and title of certifier: ▶ David P Zajano
29c. License number: D17996
29d. Dete signed *(Month, Day, Year)*: January 5, 1997

30. Neme and address ot person who completed cause ot death (Item 23a) (Type, Print): David Zajano M.D. 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Dete tiled *(Month, Day, Year)*: JAN 07 1997
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00159

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leila C. Stuckey
2. Date of Death — Month: January Day: 1 Year: 1997
3. Time of Death: 3:37Am
4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly, MD
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 44 5966
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1920
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 4001 Welsley Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Childrens Hospital

17. Father's Name (First, Middle, Last): Marine Crosswell
18. Mother's Name (First, Middle, Maiden Surname): Lou Ellen McFall

19a. Informant's Name/Relationship (Type, Print): Kathryn S. McCarthy Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4001 Welsley Lane Bowie Maryland 20715

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 1/2/97
20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: ▶ Robert E. Evans, Pres.
22. Name and Address of Facility: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic immunoblastic lymphoma	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Diabetes	
	Due to (or as a consequence of):	
	c. Hypertension	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Madalene K. Greene, M.D.
29c. License number: D38031
29d. Date signed (Month, Day, Year): 1/1/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Madalene Greene, M.D. 3231 Superior Lane A-6 Bowie, MD 20715

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: ▶ Nina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00160

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: STEVEN MARK SHAFFER

2. Date of Death Month: JAN. Day: 2 Year: 1997

3. Time of Death: 4:13 AM

4a. Facility Name *(If not institution, give street and number)*: 3306 HILLSMERE RD.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-52-6984

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 48 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: MAY 12, 1948

9. Birthplaca *(State or Foreign Country)*: MARYLAND

Usual Rasidence of Dacedant

10a. Stata: MD

10b. County: MONTGOMERY

10c. City, Town or Location: KENSINGTON

10d. Inaida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 3214 EDGEWOOD RD

10f. Zip Coda: 20895

10g. Citizan of What Country?: USA

11. Marital Status: 1 [X] Naver Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armad Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amaricen Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARTOGRAPHER

16b. Kind of Businass/Industry: COMMERCE DEPT.

17. Fathar's Name *(First, Middle, Last)*: DAVID SHAFFER

18. Mothar's Nama *(First, Middle, Maiden Surname)*: LILLIAN SHEMER

19a. Informant's Name/Relationship *(Type, Print)*: DAVID SHAFFER (FATHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 3306HILLSMERE RD. BALTIMORE, MD 21207

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramaval from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BETH EL MEMORIAL PARK

Data: 1/3/97

20c. Location - City or Town, Stata: RANDALLSTOWN, MD

21. Signature of Funaral Service Licensee

22. Nama and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on each line.

Approximate Interval Between Onsat and Death

Immediata Cause (Final disaasa or condition resulting in daath)

a. Congestive Heart Failure — 12 yrs.

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avents resulting in daath) Last

b. Restrictive cardiomyopathy — 20 yrs.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco uaa contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [X] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Cartifying Physician**: To tha best of my knowladga, death occurrad at tha tima, data and placa, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of axamination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and dua to the causa(s) and manner stated.

29b. Signature and title of cartifiar: MD

29c. Licansa number: D 24740

29d. Data signed *(Month, Day, Year)*: Jan 2nd 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS A TRAILL MD, Johns Hopkins Hospital Baltimore.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00161

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLANCHE L. SHIPLEY

2. Date of Death Month Day Year: JANUARY 03, 1997

3. Time of Death: 1:35PM

4a. Facility Name *(If not Institution, give street end number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-18-3328

6. Sex: 1☐ M XX F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 07-31-1910

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: ROGERS FORGE

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 6825-B BLENHEIM ROAD

10f. Zip Code: 21212

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 YEARS. College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FOOD SUPERVISOR

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name *(First, Middle, Last)*: FULTON LOWMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: IDELLA LOWMAN

19a. Informant's Name/Relationship *(Type, Print)*: BONNIE S.SERPICK (DAUGH.)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 39 MALIBU COURT, TOWSON,MARYLAND, 21204

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MORELAND MEM.PARK 1-6-97

Date

20c. Location - City or Town, State: BALTO.,MD.,21234

21. Signature of Funeral Service Licensee: R. D. Lee

22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on aech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEART FAILURE WITH ATRIAL FIBRILLATION — 72 HOURS

Due to (or as a consequenca of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Phyafcfan**: To tha best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2☐ **Madicaf Examfner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and dua to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ceballos, MD

29c. License number: D25886

29d. Date signed *(Month, Dey, Year)*: 1.4.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LILIA CEBALLOS, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00162

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Merrill Clair Trader, Jr.

2. Date of Death: Month Jan. Day 3 Year 1997

3. Time of Death: 1453

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-26-8107

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 21, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 145 Pittston Circle

10f. Zip Code: 21117

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1962-1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Food Store

17. Father's Name (First, Middle, Last): Merrill Clair Trader, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ella Mae Elliott

19a. Informant's Name/Relationship (Type, Print): Richard Trader

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Wally Ct., Lutherville, Md. 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem. | Date: 01/07/97

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: H. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — Ten minutes

Due to (or as a consequence of):
b. Coronary Artery Disease — Ten years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. McL

29c. License number: D33184

29d. Date signed (Month, Day, Year): January 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Kushner 114 Business Center Drive Reisterstown, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00163

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLAUDINE BUSH VELENOVSKY

2. Date of Death Month Day Year: JANUARY 5, 1997

3. Time of Death: 12:50 PM

4a. Facility Name *(If not institution, give street and number)*: 1301-C SHERIDAN PLACE

4b. City, Town, or Location of Death: BEL AIR

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 231243713

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 8, 1923

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: HARFORD

10c. City, Town or Location: BEL AIR

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1301-C SHERIDAN PLACE

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERICAL WORK

16b. Kind of Business/Industry: RAILROAD

17. Father's Name *(First, Middle, Last)*: CLAUDE BUSH

18. Mother's Name *(First, Middle, Maiden Surname)*: LENA ATKINS

19a. Informant's Name/Relationship *(Type, Print)*: JAMES J. VELENOVSKY / HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1301-C SHERIDAN PLACE BEL AIR, MD 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY

Date: 1/9/97

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — Year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D-17041

29d. Date signed *(Month, Day, Year)*: 6 Jan 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marc I. Leavey MD. 7600 Osler Drive · Ste 315 · Baltimore · MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00164

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert W. Word

2. Date of Death Month / Day / Year: JANUARY 04, 1997

3. Time of Death: 11:30P

4a. Facility Name *(If not institution, give street and number)*: Caton Manor Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-36-4502

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 22, 1929

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 712 N. Grantley Street

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Roosevelt Word

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Slaton

19a. Informant's Name/Relationship *(Type, Print)*: Irene E. Word (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 712 N. Grantley Street Baltimore, Md. 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery — Date: 1/10/97

20c. Location - City or Town, State: Woodlawn, Md.

21. Signature of Funeral Service Licensee: Donald B. Caple

22. Name and Address of Facility: Caple Funeral Service 5502 Winner Avenue Baltimore, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma — 1mo

Due to (or as a consequence of):
b. Carcinoma of Lung — 1yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Baskaran

29c. License number: D21649

29d. Date signed *(Month, Day, Year)*: January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMBANDAM BASKARAN 3455 Wilkens Ave Baltimore, Md 21229

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

RKD

97-0098-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEONARD WIGGINS
2. Date of Death (Month, Day, Year): JANUARY 5, 1997
3. Time of Death: 10:20A.M
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 216-52-2682
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5 17 1949
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 839 George St
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Bakery

17. Father's Name (First, Middle, Last): Leonard Wiggins Sr
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Sister Carolyn Wiggins
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4108 Park Hgts Ave Balto Md 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion Cemetary | Date: 1/9/97
20c. Location - City or Town, State: Landsdown Md

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: 5151 Baltimore National Pike Vaughn C Greene Funeral Service

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. ARTHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Marjorie Snell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 6, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYSAYDS A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: ▶ Linda Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00166

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Daniel Walker

2. Date of Death Month: 01 Day: 04 Year: 97

3. Time of Death: 6:00 AM

4a. Facility Name *(If not institution, give street and number)*: ALICE MANOR NURSING HOME

4b. City, Town, or Location of Death: CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 224-07-5526

6. Sex: 1☑ M 2☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-23-20

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 3042 WINSOR AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LONG SHOREMAN

16b. Kind of Business/Industry: Shipping

17. Father's Name *(First, Middle, Last)*: JERIMIAH WALKER

18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: EUNICE LYNCH (COUSIN)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2501 VIOLET AVE, APT #1302, BALTO. MD 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEMORIAL PARK

Date: 1-10-97

20c. Location - City or Town, State: RANDALLSTOWN MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. PROSTATE CANCER WITH METASTASES — 2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NONE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John A. Richardson ATTENDING PHYSICIAN

29c. License number: AR2315174

29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3333 N. CALVERT ST, STE 325 BALTIMORE MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: ▶ Linda Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00167

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thelma M. Wadsworth
2. Date of Death Month: 1 Day: 4 Year: 97
3. Time of Death: 2:50 PM
4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 142-28-0049
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 29, 1936
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4803 Fleet Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Frank Akers
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Brooks

19a. Informant's Name/Relationship *(Type, Print)*: Thelma J. Wadsworth (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4803 Fleet Street, Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery
Date: 1-8-97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	COPD exacerbation	9 days
Due to (or as a consequence of): b.	Left pneumothorax	8 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Westerman, M.D.
29c. License number: 96121
29d. Date signed *(Month, Day, Year)*: 1/4/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael Westerman, M.D. Johns Hopkins Bayview Medical Center

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — 97 00168

Certificate of Death

Reg. No.

ITEM#19a,20b,20c PRE F.H. FILM#G743 1-7-97 J.A.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Warren, Ismay

2. Date of Death — Month: Jan — Day: 3 — Year: 97

3. Time of Death: 18:27 pm

4a. Facility Name (If not institution, give street and number): 740 Poplar Grove St. Apt. 3-J

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: None

Funeral Director

5. Social Security Number: 220906611

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06 - 22 - 22

9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: Maryland

10b. County: None

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 740 Poplar Grove St. Apt. 3-J

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 9

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Mason

16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Festos Warren

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): JUDITH WRIGHT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4209 Old Milford Mill Rd. Balto., Md. 21208

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Pleca of Disposition (Name of cemetery, crematory or other placa): MT. ZION CEMETERY

Date: 1/11/97

20c. Location - City or Town, Stete: LANSDOWNE, MD.

21. Signeture of Funerel Service Licensee: Derrick C. Jones

22. Name and Address of Facility: The Derrick C. Jones Funeral Home, 4611 Park Heights Ave. Balto., Md. 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or compiications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory errest, shock, or haert failura. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceusa (Final diseese or condition resulting in death)

a. Carcinoma of the Stomach

Due to (or as a consequence of):

b. with hepatic metastases

Sequentieily list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of Stroke
History of hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Wara autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Pleca of Deeth (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residenca 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Neturai 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarminad

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury oocurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: Moges Gebrewariam

29c. License number: D18327

29d. Date signed (Month, Day, Year): Jan 6 1997

30. Name and address of person who completed causa of death (Item 23e) (Type, Print): Moges Gebrewariam 4660 Wilkens Ave Balto 21229

State Registrar

31. Dete filed (Month, Day, Year): JAN 07 1997

32. Registrar's Signature: June Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

97 00169

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Audrey Jane Watts

2. DATE OF DEATH (Month, Day, Year): 01 04 97

3. TIME OF DEATH: 5:35 p M

4. SOCIAL SECURITY NUMBER: 579-38-8803

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Dec. 17, 1929

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Carroll Lutheran Village

9b. CITY, TOWN OR LOCATION OF DEATH: Westminster

9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Carroll

10c. CITY, TOWN OR LOCATION: Westminster

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 200 St. Luke Circle

10f. ZIP CODE: 21158

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife

16b. KIND OF BUSINESS/INDUSTRY: Homemaker

17. FATHER'S NAME (First, Middle, Last): Archie Finagin, Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Rawlings

19a. INFORMANT'S NAME (Type/Print): Eldon C. Watts, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1018 Oak Tree Drive, Westminster, Md. 21158

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Mem. Gardens — DATE: Jan. 7, 1997

20c. LOCATION — City or Town, State: Finksburg, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Scott Eckhardt

22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, 11605 Reisterstown Rd. Owings Mills, Md. 2111[illegible]

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchopneumonia — Approximate Interval Between Onset and Death: 1 WK

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alz Rimers Disease — years

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D 906

29d. DATE SIGNED (Month, Day, Year): ▶ 1/04/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. A. CARICOFE MD. P.O. Box 1110 Union Bridge Md 21791

31. DATE FILED (Month, Day, Year): JAN 07 1997

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JA

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HOWARD WALL
2. Date of Death Month JANUARY Day 5 Year 1997
3. Time of Death 1900 Hrs
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-20-3493
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 1, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2425 Westchester Avenue
10f. Zip Code: 21043
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): supervisor engineer
16b. Kind of Business/Industry: community college

17. Father's Name (First, Middle, Last): Royal Wall
18. Mother's Name (First, Middle, Maiden Surname): Ella Linder

19a. Informant's Name/Relationship (Type, Print): Ms. Thelma Wall/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2425 Westchester Avenue, Ellicott City, MD 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Good Shepherd Cemetery
Date: 1-9-97
20c. Location - City or Town, State: Ellicott City, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535
22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. COPD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D77333
29d. Date signed (Month, Day, Year): JANUARY 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI, MD, MHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00171

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Stanly Whitaker

2. Date of Death Month / Day / Year: JANUARY 1 1997

3. Time of Death: 1:27 AM

4a. Facility Name *(If not institution, give street and number)*: Montgomery Genral Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery Co.

Funeral Director

5. Social Security Number: 220-44-4588

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 18, 1915

9. Birthplace *(State or Foreign Country)*: North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard County

10c. City, Town or Location: Clarksville

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 5480 Ten Oaks Road

10f. Zip Code: 21029

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 42-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Physician

16b. Kind of Business/Industry: Private practice

17. Father's Name *(First, Middle, Last)*: R. Earl Whitaker

18. Mother's Name *(First, Middle, Maiden Surname)*: Elsa Meyer Boyd

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Marie A. Whitaker/spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5480 Ten Oaks Road, Clarksville, Maryland 21029

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Washington Crematory

Date: 1-2-97

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 7 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

CONGESTIVE HEART FAILURE

CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D25947

29d. Date signed *(Month, Day, Year)*: JANUARY 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EVELYN STENSON, MD 5540 TEN OAKS RD., CLARKSVILLE, MD 21029

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within [illegible] hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00172

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: JANET L. YOUNG

2. Date of Daeth — Month: JAN Day: 4 Yaar: 97

3. Tima of Death: 0435

4a. Faclity Neme *(If not institution, giva straat and number)*: Carroll County General Hospital

4b. City, Town, or Location of Daeth: Westminster

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 220-42-7503

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 54 Yrs.

If Under 1 Yaar — Months: Deys:

If Undar 24 Hrs. — Hours: Min.

8. Date of Birth *(Month, Dey, Yaar)*: Nov. 25, 1942

9. Birthplace *(State or Foraign Country)*: Washington, DC

Usual Rasidanca of Decadent

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 429 Old Trail

10f. Zip Coda: 21212

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Marriad 2☐ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Detes:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican indian, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade compiated)* — Elementary/Secondary (0-12): — College (1-4or 5+): 2

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Librarian's Assistant

16b. Kind of Businass/Industry: Clerical

17. Fathar's Name *(First, Middla, Last)*: Irvin Earl Young

18. Mothar's Nama *(First, Middla, Maidan Surnema)*: Elizabeth Lou Martin

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Joan Middendorf (sister)

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda)*: 505 Danmarth Road Sykesville, MD 21784

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or other piece)*: Woodlawn Cemetery

Deta: 1/7/97

20c. Location - City or Town, State: Baltimore, MD

21. Signatura of Funaral Service Licansee: ▶ Brian L. Haight

22. Nama and Addrass of Facility: HAIGHT FUNERAL HOME & CHAPEL (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the deeth. Do not anter tha moda of dying, such es cardiac or raspiratory arrest, shock, or heart feilura. List only one causa on aach lina.

Approximata Intarval Batween Onsat and Deeth

Immadieta Ceusa (Final disease or condition rasulting in daath)

a. POSSIBLE SEPTICAEMIC SHOCK — 10 HRS

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated events resulting in daath) Lest

b.

Due to (or as a consaquanca of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying causa givan in Part I.: MULTIPLE SCLEROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings aveilebla prior to complation of causa of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)* — Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residanca 8☐ Othar *(Specify)*

27. Mannar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of injury - At homa, farm, streat, fectory, offica building, etc. *(Spacify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, daath occurred at tha tima, date and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and placa, and due to the causa(s) and manner stated.

29b. Signatura and title of certifiar: ▶ Hafeez A Syed M.D

29c. Licensa number: D25052

29d. Deta signed *(Month, Dey, Yaar)*: 1/4/97

30. Name and address of person who compiated cause of deeth (Item 23a) (Type, Print): HAFEEZ A SYED 20 CROSSROADS DR, OWINGS MILLS MD 21117

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 07 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00173

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pauline Zick

2. Date of Death Month / Day / Year: January 5 1997

3. Time of Death: 9:10A

4a. Facility Name *(If not institution, giva street and number)*: Frederick Villa Nursing Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-05-2655

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 7, 1903

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Residance of Dacedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 5215 Larlin Road

10f. Zip Coda: 21227

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yeer or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedant's Educetion *(Specify only highast grada complated)*: Elamentary/Secondary (0-12): 3 / Coliega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: homemaker

16b. Kind of Businass/Industry: own home

17. Fathar's Name *(First, Middla, Last)*: Hugo Huether

18. Mothar's Name *(First, Middla, Maiden Sumama)*: Mollie Preuss

19a. Informant's Name/Ralationship *(Type, Print)*: Mary Zick, daughter in law

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5215 Larlin Road Baltimore, Maryland21227

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar place)*: Loudon Park Cemetery

Data: 1/9/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensaa: Paul W. Hagan

22. Nama and Addrass of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart fallura. List only ona cause on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediata Causa (Final diseasa or condition rasulting in daath)

a. Pneymonia — Four days

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying ceusa given in Part I.

23b. Did tobacco uas contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to compiation of causa of death? 1☐ Yas 2☒ No

25. Was cesa rafarrad to medicei examinar? 1☐ Yes 2☒ No

28. Placa of Death *(Check only ona)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, straet, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: ☒ **Certifying Phyaician**: To tha best of my knowiedga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. ☐ **Madtcat Examiner**: On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mennar stetad.

29b. Signature and title of certifier: Patrick W. White M.D

29c. License number: DZ3365

29d. Dete signed *(Month, Day, Year)*: January, 6, 1997

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Patrick White, M.D. 716 Maiden Choice LN - 205

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 07 1997

32. Registrar's Signatura: Gina Davidson-Randelle

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0008-510
B.K.S
ITEMS· 23 PART I, PER MEO
FILM g-743 1/30/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
Item: 23 Part I, per MEO G-745 3/26/97 reb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL RAYMOND ASHLEY
2. Data of Deeth: Month JAN. Dey 1, Yaer 1997
3. Tima of Deeth: 0534 AM
4a. Facility Nema (If not institution, giva street end number): JOHNS HOPKINS BAYVIEW HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-72-5043
6. Sax: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 38 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Feb. 8, 1958
9. Birthplece (State or Foraign Country): Maryland

To Be Completed by Funeral Director

Usual Residance of Dacedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Locetion: Dundalk
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Streat end Numbar: 1620 Gray Place
10f. Zip Coda: 21222
10g. Citizan of What Country?: United States
11. Mantel Stetus: 1☐ Navar Merriad 2☒ Married 3☐ Widowad 4☐ Divorcad
12. Wes Dacedant Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American indian, Bleck, Whita, etc. Specify: White
15. Decedent's Education (Specify only highast grade complated): Elementary/Secondary (0-12): 12 Years; Collaga (1-4or 5+):
16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Deli Clerk
16b. Kind of Businass/Industry: Food Industry
17. Fethar's Name (First, Middla, Last): Virgil Ashley
18. Mothar's Name (First, Middla, Maidan Sumama): Wanda P. Podbielska
19a. Informant's Name/Ralationship (Type, Print): Mrs. Patricia L. Ashley/Wife
19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1620 Gray Place Dundalk, Maryland 21222
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)
20b. Piace of Disposition (Name of cematary, cramatory or othar place): Oak Lawn Cemetery
Data: 01/06/1997
20c. Location - City or Town, Steta: Baltimore, MD
21. Signature of Funaral Servica Licensae: Gregory E Ruck
22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or raspiretory errast, shock, or haart feilura. List only ona causa on aach lina.

Approximete Intarval Batween Onsat and Death

Immadiata Causa (Finel disaasa or condition resulting in daath): e. PNEUMONIA AND

Dua to (or as a consaquance of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Ceusa (Disaasa or injury thet initiated events resulting in daath) Last:
b.
Dua to (or es e consaquance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditiona** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

23b. **Did tobecco uee contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☑ **Unknown**

24a. Was an eutopsy performad? 1☑ Yes 2☐ No

24b. Wara autopsy findings evellabla prior to completion of ceuse of daath? 1☑ Yas 2☐ No

25. Was casa raferred to madical examinar? 1☒ Yas 2☐ No

26. Piaca of Death (Chack only ona): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Daath: 1☑ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datermined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Place of injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the tima, data and piece, and dua to the ceusa(s) and manner as steted. 2☒ **Medical Examiner**: On the basis of exeminetion end/or invastigetion, in my opinion, death occurred at tha tima, data and piace, end due to tha causa(s) end manner stated.

29b. Signetura and titie of certifiar: Dennis J. Chutkow
29c. Licensa number: O.C.M.E
29d. Deta signad (Month, Day, Year): JAN. 3, 1997

30. Nama and address of person who completed ceuse of death (Item 23a) (Typa, Print): Dennis J. Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00175

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tania Alves-El-Barnhill

2. Date of Death: Month 01 Day 02 Year 1997

3. Time of Death: 1805h

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-78-9785

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): NOV 12, 1958

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1024 N. Carrollton Ave

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 1yr.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cosmotologist

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): William Barnhill Jr.

18. Mother's Name (First, Middle, Maiden Surname): Gwendolyn Evans

19a. Informant's Name/Relationship (Type, Print): John Alvez-El

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1024 N. Carrollton Ave Balto, 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: 1/10/97

20c. Location - City or Town, State: Lansdowne, md

21. Signature of Funeral Service Licensee: Sharon Stokes

22. Name and Address of Facility: Mason F. H. West 4300 Wabash Ave

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in daath)

a. Pneumocystis Carini Pneumonia — Days

Dua to (or as a consequence of):

b. AIDS — Years

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: Christian D Bounds MD

29c. License number: P10207

29d. Date signed (Month, Day, Year): 01/02/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christian D Bounds, MD UMMS 22 S. Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY O. BLIMLINE
2. Date of Death (Month, Day, Year): JANUARY 6, 1997
3. Time of Death: 7:15pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Med. Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-07-8860
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.3,1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2616 Ambler Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 yrs. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Boiler Room Operator
16b. Kind of Business/Industry: Beth. Steel

17. Father's Name (First, Middle, Last): Henry F. Blimline
18. Mother's Name (First, Middle, Maiden Surname): Dorothy A. Wischhusen

19a. Informant's Name/Relationship (Type, Print): May Blimline wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2616 Ambler Rd. Dundalk Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens Of Faith
Date: 1-10
20c. Location - City or Town, State: Rossville

21. Signature of Funeral Service Licensee: John Connelly Jr
22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CONGESTIVE AND DILATED CARDIOMYOPATHY	4 YEARS
Due to (or as a consequence of): b.	ARTERIOSCLEROTIC HEART DISEASE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEVERE EMPHYSEMA, OBESITY, HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Aurora C. Tan, M.D.
29c. License number: D14958
29d. Date signed (Month, Day, Year): JANUARY 7, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): AURORA C. TAN, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00177

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DAVID WALTER BENNETT

2. Date of Death — Month: JANUARY Day: 4 Year: 1997

3. Time of Death: 12:15 PM

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bayview

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 237-24-7246

8. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 30, 1922

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: [ ] 1 Yes [X] 2 No

10e. Street and Number: 98 Delmar Ave.

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 yrs. College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Walter Clark Bennett

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Pindell

19a. Interment's Name/Relationship *(Type, Print)*: Catherine Bennett wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 98 Delmar Ave. Dundalk Md. 21222

20a. Method of Disposition: [ ] 1 Burial [X] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 1-7

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: John Connelly

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. cerebrovascular accident — 2 d

Due to (or as a consequence of): myocardial infarction — 12 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [X] 1 Yes [ ] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [X] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)* — Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA — Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other *(Specify)*

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Douglas Kerr — DOUGLAS KERR NEUROLOGY RESIDENT JOHNS HOPKINS HOSPITAL

29c. License number: AJ4141357: N9951

29d. Date signed *(Month, Day, Year)*: JANUARY 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Douglas Kerr, MD JHBMC 4940 Eastern Ave Baltimore MD 21224

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Davidson-Mendez

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia F Brown
2. Date of Death: Month Jan Day 3 Year 97
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-05-4008
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 9, 1912
9. Birthplace (State or Foreign Country): Ireland

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7809 Bodkinview Drive
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): home maker
16b. Kind of Business/Industry: household

17. Father's Name (First, Middle, Last): John O'Connell
18. Mother's Name (First, Middle, Maiden Surname): Rose Mullins

19a. Informant's Name/Relationship (Type, Print): Patricia Jerabek/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 Anasazi Road, Placitas, New Mexico 87043

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade, Director
22. Name and Address of Facility: StateAnatomy Board, 655 West Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

20a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) e.	Pneumonia	1 week
Due to (or as a consequence of):		
Sequentieily list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last b.	Congestive heart failure	1 week
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Internist
29c. License number: D37013
29d. Date signed (Month, Day, Year): Jan. 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bruce M Conger MD Suite 210 11055 Little Patuxent Pkwy Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: ▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARENCE E. BALLENTINE

2. Date of Death: Month JAN Day 3 Year 1997

3. Time of Death: 2045

4a. Facility Name (If not institution, give street and number): 7961 BANK STREET

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-20-5978

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Oct.5 1925

9. Birthplace (State or Foreign Country): MAryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7961 Bank Street

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 1st

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAborer

16b. Kind of Business/Industry: Eastern StainlessSteel

17. Father's Name (First, Middle, Last): Clarence E. Ballentine

18. Mother's Name (First, Middle, Maiden Surname): Amelia D. Bobart

19a. Informant's Name/Relationship (Type, Print): Lillian M. Majer /sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7961 Bank Street Balitmore Md. 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 1/6/97

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic ischemic myocardial disease — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ___

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Crossan O'Donovan, M.D.

29c. License number: D07632

29d. Date signed (Month, Day, Year): January 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. CROSSAN O'DONOVAN, M.D. 2112 DUNDALK AVE. BALTO MD 21222

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: ▶ Julia Davidson-Ramsey

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00180

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carolyn Cox

2. Data of Death — Month: Jan; Day: 3; Yaar: 97

3. Tima of Death: 3:10Am

4a. Facility Nama *(If not institution, giva street and numbar)*: Bon Secours

4b. City, Town, or Location of Daath: Balto.

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-30-8821

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Yaar)*: May 18, 1931

9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidanca of Decedant

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 55 Wade Avenue

10f. Zip Code: 21228

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Naver Married 2☐ Married 3☐ Widowed 4☒ Divorcad

12. Was Decedant Evar in U.S. Armad Forces? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Austin Unknown Shores

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Violet Marie Klein

19a. Informant's Name/Ralationship *(Type, Print)*: Sharon Marie Kaufman/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 124 West Franklin Street, New Freedom, Pennsylvania 17349

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar place)*: Chesapeake Crematory — Data: 1/6/97

20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signature of Funaral Sarvica Licansaa: Juanita R Thomas

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications thet caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only ona causa on each lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Finel diseasa or condition resulting in daath)

a. PNEUMONIA — Approximata Intarval: 2 wks

Dua to (or as a consequance of):

Saquantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avants resulting in daath) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☐ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was case rafarred to medical examinar? 1☐ Yas 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Daath: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: John Sloan

29c. License number: D27838

29d. Data signed *(Month, Day, Yaar)*: 1/3/97

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): JOHN SHIVERS 518 CAMPBELL RD LINTHICUM, MD 21090

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 08 1997

32. Registrar's Signatura: Lisa Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00181

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VEMA MAE CARNAHAN
2. Date of Death Month Day Year: January 5, 1997
3. Time of Death: 6:30 AM
4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 201-18-6016
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 10, 1906
9. Birthplace *(State or Foreign Country)*: Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8921 D. Waltham Woods Rd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager
16b. Kind of Business/Industry: City of Harrisburg Housing Authority
17. Father's Name *(First, Middle, Last)*: Wallace B. Carnahan
18. Mother's Name *(First, Middle, Maiden Surname)*: Grace V. Fortney
19a. Informant's Name/Relationship *(Type, Print)*: Mr. W. Bruce Smith
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8400 Harris Ave. Baltimore, Md. 21234
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: East Harrisburg Cemetery
Date: 1/8/97
20c. Location - City or Town, State: Harrisburg, Pa.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA
Due to (or as a consequence of): ASPIRATION
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: 044560
29d. Date signed *(Month, Day, Year)*: 1/6/97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 10755 FALLS RD SUITE 460 LUTHERVILLE, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00182

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH JOHN CASCIO
2. Date of Death Month Day Year: January 4, 1997
3. Time of Death: 6:26 AM
4a. Facility Name *(If not institution, give street and number)*: 8320 Dalesford Rd.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-03-3933
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 18, 1916
9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8320 Dalesford Rd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Political Lobbyist
16b. Kind of Business/Industry: Local Union 27

17. Father's Name *(First, Middle, Last)*: Joseph Cascio
18. Mother's Name *(First, Middle, Maiden Surname)*: Olivia Mary Battaglia

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Frances F. Cascio/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8320 Dalesford Rd. Parkville, Md. 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gdns. — Date: 1/8/97
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Adeno CA Colon — 6 yrs.
Due to (or as a consequence of):
b. Mets to Brain and
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Mets to lung
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32929
29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RICHARD G. D'ANTONIO, M.D.
7401 OSLER DRIVE #201
TOWSON, MD 21204
(410) 825-3416

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEANNE R. COOPER
2. Date of Death (Month, Day, Year): January 5, 1997
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): 3117 Cedarhurst Road
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 213-42-4564
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 28, 1915
9. Birthplace (State or Foreign Country): Pennsylvannia

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3117 Cedarhurst Road
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 yr's
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Nicholas Renzi
18. Mother's Name (First, Middle, Maiden Surname): Marie DeCaro

19a. Informant's Name/Relationship (Type, Print): Mr. James E. Cooper - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2716 Baldwin Mill Road Baldwin, MD 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Moreland MemorialPark
Date: 1/8/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Paul F. Heatwole
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — hours

Due to (or as a consequence of):
b. Bronchogenic Carcinoma — 6months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Thomas Wilson
29c. License number: D40277
29d. Date signed (Month, Day, Year): January 6, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Thomas Wilson, M.D. 5601 Loch Raven Blvd.

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

WRC
97-0085-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FilmG743 item 24a,27 per ME 1-8-97 rja

Certificate of Death

Reg. No. 97 00184

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY COLEMAN

2. Date of Death Month JAN. Day 05, Year 1997

3. Time of Death 3:26 PM.

4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS BAYVIEW HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-51-2746

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 7, 1936

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: VA

10b. County: Bedford

10c. City, Town or Location: Vinton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Rt. 1 Box 715

10f. Zip Code: 24179

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Clark Jackson

18. Mother's Name *(First, Middle, Maiden Surname)*: Doris Croston

19a. Informant's Name/Relationship *(Type, Print)*: George Coleman/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Rt. 1 Box 716 Vinton, Virginia 24179

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Blue Ridge Mem. Gdns.

Date: 01/09/1997

20c. Location - City or Town, State: Roanoke, VA

21. Signature of Funeral Service Licensee: Johnny L Dodd

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? Inspection 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

26a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JAN. 06, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZELDA L CEPHAS

2. Data of Death — Month: JANUARY Day: 6, Yaar: 1997

3. Tima of Death: 7:20 PM

4a. Facility Nama (If not institution, giva straat and number): SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Sacurity Number: 214-38-7839

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 56 Yrs.

If Under 1 Yaar — Months / Days

If Undar 24 Hrs. — Hours / Min.

8. Data of Birth (Month, Day, Yaar): NOV 1, 1940

9. Birthplaca (State or Foraign Country): Md

Usual Rasidanca of Decedant

10a. Stata: Md

10b. County: N I A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 2929 Gwynn Falls Pkwy

10f. Zip Coda: 21216

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highast grada completed) — Elamantary/Saccondery (0-12): 12th — Collaga (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad): Quality Control

16b. Kind of Businass/Industry: Manufacturing Co.

17. Fathar's Nama (First, Middle, Last): Paul Cephas

18. Mothar's Nama (First, Middle, Maidan Surnama): Alice Tull

19a. Informant's Name/Ralationship (Type, Print): Robert Cephas- Brother

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 2929 Gwynn Falls Pkwy Balto, md 21216

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): King Mem Pk

Data: 1/11/97

20c. Location - City or Town, Stata: Randallstown, md

21. Signature of Funaral Sarvica Licansaa: Gabrielle Curtz

22. Nama and Addrass of Facility: March F. H. West, 4300 Wabash Ave

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)

a. RESPIRATORY FAILURE

Due to (or as a consaquanca of):

b. METASTATIC BREAST CANCER

Saquantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that Initiatad avants rasulting in daath) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to compiation of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

28. Placa of Death (Check only ona) — Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To tha best of my knowladga, daath occurrad at tha time, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and title of certifier

29c. Licansa number: D37254

29d. Data signed (Month, Day, Yaar): 1/7/97

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Data filed (Month, Day, Yaar): JAN 08 1997

32. Registar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00186

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERTA CARPENTER
2. Date of Death Month: JANUARY Day: 6 Year: 1997
3. Time of Death: 4:50 PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 212-03-1761
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 26, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3110 River Bend Court, Unit #G104
10f. Zip Code: 20724
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): Ø
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Edward Imhoff
18. Mother's Name (First, Middle, Meiden Surname): Bridget Dell

19a. Informant's Name/Relationship (Type, Print): Harry G. Carpenter/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3110 River Bend Court, Unit #G104, Laurel, MD 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Cedar Hill Cemetery
Date: 1/10
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Daniel Rader
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximata Interval Between Onset end Death

Immediate Causa (Final disease or condition resulting in death)
e. Hemorrhage, Gastrointestinal — 5 hours
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causes of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) snd manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Kundrat M.D.
29c. License number: D36716
29d. Date signed (Month, Dey, Year): 1/7/97

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): ANDREW KUNDRAT M.D. 8317 CHERRY LANE, LAUREL, Md. 20707

State Registrar

31. Dete filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 2 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0023-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 5,7 per F.H. G-745 3/5/97 reb

Certificate of Death

Reg. No. 97 00187

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): OLIVER COLE
2. Dete of Deeth — Month: JAN. Dey: 2, Yeer: 1997
3. Time of Death: 0822 AM
4a. Feciity Neme (If not institution, give street end number): 3344 OLD YORK ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth:

Funeral Director

5. Social Security Number: 382-05-8766 ~~unknown~~
8. Sex: 1☒M 2☐F
7. Age (In yrs. lest birthdey): ~~90~~ 89 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): May 28, 1907
9. Birthpiece (Stete or Foreign Country): North Carolina

Usuei Residance of Decedent

10e. Stete: MD
10b. County:
10c. City, Town or Location: 3344 Old York Road
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 3344 Old York Road
10f. Zip Code: 21218
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Bleck, Whita, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondery (0-12): 8 — College (1-4or 5+): 0
16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired): Journeymen machinist
16b. Kind of Business/Industry: Tool & Dye Manufact.
17. Fether's Neme (First, Middle, Last): John Cole
18. Mother's Neme (First, Middle, Meiden Surname): Margaret Gossett
19e. Informent's Neme/Reletionship (Type, Print): Jacqueline Cole/wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3344 Old York Road, Baltimore, MD 21218
20e. Method of Disposition: 1☐Buriel 2☐Cremetion 3☐Removel from State 4☐Donetion 5☒Othar (Specify) in state
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece):
Dete:
20c. Location - City or Town, Stete:
21. Signeture of Funerei Service Licensee: Ronald S. Wades, Director
22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Entar the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or raspiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth): e. Arteriosclerotic Cardiovascular Disease

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: EPILEPSY

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? INSPECTION 1☐Yes 2☒No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical exeminer? 1☒Yes 2☐No

26. Place of Deeth (Check only one) — Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Day Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify):
28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as stated. 1☒ **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signature and titia of certifiar: Dennis J. Chuteno
29c. Licensa number: O.C.M.E
29d. Data signed (Month, Day, Yeer): JAN. 2, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis J. Chuteno 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 0 8 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00188

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR DUNLAP

2. Date of Death Month / Day / Year: JANUARY 1 1997

3. Time of Death: 1:29 AM

4a. Facility Name *(If not institution, give street and number)*: GREATER LAUREL HOSPITAL

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 216-05-0403

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8/27/16

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: JESSUP

10d. Inside City Limits: XX1Yes 2☐No

10e. Street and Number: 8224 LINCOLN DRIVE

10f. Zip Code: 20794

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 6

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OPERATOR

18b. Kind of Business/Industry: STEEL

17. Father's Name *(First, Middle, Last)*: CURLIE DUNLAP

18. Mother's Name *(First, Middle, Maiden Surname)*: JANIE DAVENPORT

19a. Informant's Name/Relationship *(Type, Print)*: GERTRUDE DUNLAP(WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8224 LINCOLN DRIVE JESSUP,MD 20794

20a. Method of Disposition: XX1Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND NAT.MEM.PK

Date: 1/6/97

20c. Location - City or Town, State: LARUEL,MD.

21. Signature of Funeral Service Licensee: Dorotha Hecth CFSP # 281

22. Name and Address of Facility: E.L. PHILLIPS FUNERAL 1721-27 N.MONROE STREET BALTO.MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular Accident — minute

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, Sepsis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William A. Warren MD

29c. License number: D13916

29d. Date signed *(Month, Day, Year)*: January 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William A Warren 321 Prince George St Laurel Md 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be completed by Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Item7 1-13-97 FilmG743 W.H.Per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00189

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Earl DURHAM

2. Date of Death Month Day Year: January 7, 1997

3. Time of Death: 1:36 a.m.

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 506-16-2730

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: ~~77~~ 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 5, 1918

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 905 Hauf Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mail Service

16b. Kind of Business/Industry: U.S. Postal

17. Father's Name *(First, Middle, Last)*: Everett Durham

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Walker

19a. Informant's Name/Relationship *(Type, Print)*: Donna Horvath (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1000 Southwick Ct. Loch Raven, Md. 21204

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens

Date: 1/11/1997

20c. Location - City or Town, State: Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Ventricular fibrillation

Due to (or as a consequence of):
Hypertensive Heart disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number: D106 13

29d. Date signed *(Month, Day, Year)*: 1-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAFAEL PEREZ-MERA, 404 Eastern Blvd., Balto. 21221

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrar's Signature: Lolia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

12 + VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00190

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ellsworth L. Domer
2. Date of Death Month: Jan. Day: 4 Year: 1997
3. Time of Death: 10:16pm
4a. Facility Name *(If not institution, give street and number)*: John Hopkins - Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-16-9240
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 14, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 402 MArgaret Ave.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 2yrs
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Western Electric

17. Father's Name *(First, Middle, Last)*: Walter Henry Domer
18. Mother's Name *(First, Middle, Maiden Surname)*: Pauline Ruth Cuno

19a. Informant's Name/Relationship *(Type, Print)*: Virginia Domer /wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 402 MArgaret Ave. Balitmore Md. 21221

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc. — Date: 1/9/97
20c. Location - City or Town, State: Balitmore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral HOme of Essex, 300 Mace Ave. Balitmore MD. 21221

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Internal Bleeding	one hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Super Therapeutic Coumadin Level	2 days
Due to (or as a consequence of):		
c.	Treatment of Pulmonary Embolism	3 months
Due to (or as a consequence of):		
d.	Deep vein Thrombosis	3 months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

Pulmonary Embolism

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: M9065
29d. Date signed *(Month, Day, Year)*: January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chin Hur Dr's Lounge, 110 Tower, JHH, Baltimore, MD 21205

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997
32. Registrar's Signature: Julia Davidson-Ramsette

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MINOR D. DONNELL
2. Date of Death (Month, Day, Year): JANUARY 5, 1997
3. Time of Death: 7:30 PM
4a. Facility Name (If not institution, give street and number): 5903 WINDHAM ROAD
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGE

Funeral Director

5. Social Security Number: 216-30-3109
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 5, 1934
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGE
10c. City, Town or Location: LAUREL
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5903 WINDHAM ROAD
10f. Zip Code: 20707
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1957 1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INTELLIGENCE ANALYST
16b. Kind of Business/Industry: US GOVERNMENT
17. Father's Name (First, Middle, Last): MINOR C. DONNELL
18. Mother's Name (First, Middle, Maiden Surname): HARRIET PROFITT
19a. Informant's Name/Relationship (Type, Print): JEAN DONNELL/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5903 WINDHAM ROAD, LAUREL, MARYLAND 20707
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE WASHINGTON CR. — Date: 1/6/97
20c. Location - City or Town, State: LAUREL, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Malignant Meningioma	17years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Brain Stem Dysfunction 2° to a	2mos
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D15896
29d. Date signed (Month, Day, Year): 1-6-97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johns Hopkins Hospital Baltimore md 21207

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00192

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Bennie Franklin Dickerson, Sr.

2. Dete of Deeth Month Day Yaar: January 2,1997

3. Time of Death: 9:26 pm

4a. Feciity Neme *(If not institution, give street and number)*: Johns Hopkins BAyview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 222-12-0583

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 72 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Dec. 24,1924

9. Birthplace *(State or Foreign Country)*: Delaware

To Be Completed by Funeral Director

Usuel Residence of Decedant

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 8512 Kavanagh Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☒Yas 2☐No If Yes, Giva Yeer or Detes: WWII

13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondery (0-12): 10 Years; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Freight

17. Father's Neme *(First, Middle, Last)*: Arthur Dickerson

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Neulon

19a. Informent's Neme/Relationship *(Type, Print)*: Nancy J. Dickerson/Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8512 Kavanagh Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetary, crematory or other place)*: Gardens of Faith Cem. | Dete: 01/06/1997

20c. Location - City or Town, Stata: Rossville, MD

21. Signature of Funaral Sarvice Licensea: ▶ Johnny L Hicks

22. Nama and Addrass of Facility: Duda-Ruck-Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseasa, or complications thet causad tha daath. Do not enter the moda of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximeta Interval Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth): a. Massive gastric hemorrhage — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest:

b. gastric ulcers — days

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Severe coronary artery atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yas 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No

26. Place of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Othar *(Specify)*

27. Menner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and piece, and dua to tha causa(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of exemination end/or investigetion, in my opinion, daath occurred at the time, data and place, and dua to tha cause(s) end manner steted.

29b. Signeture and title of certifier: ▶ Ellen Pizer

29c. License number: D 46738

29d. Date signed *(Month, Day, Year)*: January 6,1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ellen S. Pizer — Johns Hopkins Bayview Medical Center 4940 Eastern Avenue, Baltimore, MD 21224

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrer's Signature: ▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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5x1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00193

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frederick J. Fleckenstein

2. Date of Death Month: January Day: 5 Year: 1997

3. Time of Death: 11:22am

4a. Facility Name *(If not institution, give street and number)*: Manor Care- Rossville

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-14-4119

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 28,1908

9. Birthplace *(State or Foreign Country)*: MAryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9526 Perry Hall Blvd.

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Hardware Fair

17. Father's Name *(First, Middle, Last)*: Peter S. Fleckenstein

18. Mother's Name *(First, Middle, Maiden Surname)*: Teresa Morgerth

19a. Informant's Name/Relationship *(Type, Print)*: Helen Fleckenstein

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9526 Perry Hall Blvd. Baltimore Md. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St.JOseph Cemetery 1/8/97

Date:

20c. Location - City or Town, State: Fullerton MD.

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Urinary Retention

Due to (or as a consequence of):

b. Urethal Stricture — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD Dementia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard Freeland MD

29c. License number: D28127

29d. Date signed *(Month, Day, Year)*: 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard S Freeland MD 5601 Loch Raven Blvd Balto Md 21239

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrar's Signature: Richard Davidson-Hendricks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00194

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Frederick Fuchs

2. Date of Death (Month, Day, Year): Jan. 5, 1997

3. Time of Death: 6:00pm

4a. Facility Name *(If not institution, give street and number)*: 9 E Maid Stone Court

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 197-10-8926

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUne 2, 1911

9. Birthplace *(State or Foreign Country)*: NewYork

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9 E Maid Stone Court

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ChemicalPlant Operater

16b. Kind of Business/Industry: Fed Goverment

17. Father's Name *(First, Middle, Last)*: John C. Fuchs

18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel Haas

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Fuchs /wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9 E Maid Stone Court Rosedale Md. 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Cemetery | Date: 1/8/97

20c. Location - City or Town, State: Balitmore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

a. Chronic plewal effusions

Dua to (or as a consequanca of):

b. Coronary Artery disiase

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequence of):

c. Carotid artery disease

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic aspiration 2° to Laryngeal Nerve paresis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Liya Pfeffermn

29c. License number: D35410

29d. Date signed *(Month, Day, Year)*: 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Liya Pfefferman 6918 Ridge Rd Balto Md 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00195

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert FRANCIS FLADUNG

2. Date of Death Month: 1 Day: 2 Year: 97

3. Time of Death: 10:30PM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: ANNE Arundel

Funeral Director

5. Social Security Number: 213 44 3061

8. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 4, 1947

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Gambrills

10d. Inside City Limits: 1☐Yes 2☒No

10a. Street and Number: 614 Florida Place

10f. Zip Code: 21054

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Heavy Equipment Operator

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Rudolph Fladung

18. Mother's Name *(First, Middle, Maiden Surname)*: Betty Jean Life

19a. Informant's Name/Raletionship *(Type, Print)*: Barbara A. Fladung Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 614 Florida Place Gambrills Maryland 21054

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Holy Trinity Episcopal Church Cemetery Date: Jan. 5, 1997

20c. Location - City or Town, State: Bowie Maryland

21. Signeture of Funeral Service Licensee: Robert E Evans Jr

22. Neme end Address of Facility: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Causa (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Chronic Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disesse or Injury that initiated evants resulting in death) Last

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Peripheral Vascular Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Deep Venous Thrombosis Left leg

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wss case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Holly Spurrier Crawford MD

29c. License number: D21933

29d. Dete signed *(Month, Day, Year)*: 1/3/97

30. Nsme and address of person who completed cause of death (Item 23a) (Type, Print): Suite 302 611 S. Rolling Springs Rd. Arlington Va 22204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To be completed by Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1D

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00196

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNIE L. FOSTER

2. Date of Death Month: JANUARY Day: 5th Year: 97

3. Time of Death: 1:15PM

4a. Facility Name *(If not institution, give street and number)*: MERIDAN N.H./Genesis Elder Care

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-09-2141

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-28-11

9. Birthplace *(State or Foreign Country)*: Va.

Usual Residence of Decedent

10a. State: MD.

10b. County: Na

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 904 St. Dunstans Road

10f. Zip Code: Baltimore

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): NA | College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Factory

17. Father's Name *(First, Middle, Last)*: Willie Davis

18. Mother's Name *(First, Middle, Maiden Surname)*: Louvenia Davis

19a. Informent's Name/Relationship *(Type, Print)*: Angela Hamlet

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 904 St. Dunstan Road Baltimore, MD. 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem. Pk. Cem. | Date: 1-09-97

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: Deborah K. Davis

22. Name and Address of Facility: MARCH F.H. EAST 1101 E. NORTH AVE.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. cerebro Vasculer accident

Due to (or as a consequence of):
b. gastrostomy tube feeding

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hyperthyroidism

Due to (or as a consequence of):
d. Peripheral Vasculer disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residenca 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred et the time, dete and placa, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sireesh K. Tripuraneni

29c. License number: D 30661

29d. Date signed *(Month, Day, Year)*: January 6th 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SIREESH K. TRIPURANENI 5670 The Alameda, Baltimore, Md - 21239.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

2

97 00197

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or if item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ann J. Folks			2. DATE OF DEATH (Month / Day / Year): 1 / 5 / 97	3. TIME OF DEATH: 7:10 PM
4. SOCIAL SECURITY NUMBER: 579-24-8559	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 1, 1926	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): Golden Oaks Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: LAUREL	9c. COUNTY OF DEATH: PRINCE GEORGE	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: LAUREL	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 14715 BOWIE ROAD		10f. ZIP CODE: 20708	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): Ø	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home		
17. FATHER'S NAME (First, Middle, Last): WILLIAM BORDEN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARJORIE ANDREWS		
19a. INFORMANT'S NAME (Type/Print): TOMMY LEE FOLKS/HUSBAND		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14715 BOWIE ROAD, LAUREL, MARYLAND 20708		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Washington Cr. DATE: 1/6	20c. LOCATION — City or Town, State: Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Daniel R Fleck		22. NAME AND ADDRESS OF FACILITY: FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the lung	7 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis R Schriver | 29c. LICENSE NUMBER: D15666 | 29d. DATE SIGNED (Month, Day, Year): ▶ 1/6/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dennis R Schriver 14724 LAUREL PK DR #102 LAUREL MD 20707

31. DATE FILED (Month, Day, Year): JAN 08 1997 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

1

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00198

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): Charlotte GUTOWSKI
2. Dete of Deeth: Month January Dey 4, Yeer 1997
3. Time of Deeth: 2:07 PM
4e. Fecility Neme (If not institution, give street end number): Franklin Square Hospital Center
4b. City, Town, or Location of Deeth: Rossville
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 212-30-6071
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): JAN. 19,1934
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 348 Nicholson Road
10f. Zip Code: 21221
10g. Citizen of What Country: USA
11. Meritel Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Blecк, White, etc. Specify: White
15. Decedent's Eduction (Specify only highest grede completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Cable Former
16b. Kind of Business/Industry: Western Electric
17. Fether's Neme (First, Middle, Last): William J. Underwood
18. Mother's Neme (First, Middle, Maiden Surneme): Alice MArie Musch
19e. Informent's Neme/Reletionship (Type, Print): Dawn Murphy / daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 33 Pelczar Ave. Balitmore Md. 21221
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Garrison Forest Cemetery
Dete: 1/7/97
20c. Locetion - City or Town, Stete: Owings Mills Md.
21. Signeture of Funerel Service Licensee: R Terry Connelly
22. Neme end Address of Fecility: Connelly Funeral Home of Essex 300 Mace Ave. Balitmore Md. 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Cardiogenic Shock — 2 Hours

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest:

b. Acute Myocardial Infarction

Due to (or es e consequence of):

c. Coronary Artery Disease

Due to (or es e consequence of):

d. Atherosclerosis

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Hypertension

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:
29c. License number: D 42083
29d. Dete signed (Month, Dey, Yeer): January 4,1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Gunta Wheeler MD. 9000 Franklin Square Dr. Balto, Md. 21237

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 0 8 1997
32. Registrer's Signeture: Julie Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00199

Item:5 per informant G-757 3/3/98 dh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Percy Holland

2. Date of Death: Month January Day 2, Year 1997

3. Time of Death: 8:40 AM

4a. Facility Name (If not institution, give street and number): Laurel Baltimore Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-56-1295

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 8, 1951

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Anne Arundel

10c. City, Town or Location: Jessup

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: MD. House of Correction

10f. Zip Code: 20794

10g. Citizen of What Country? U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction

16b. Kind of Business/Industry: Building

17. Father's Name (First, Middle, Last): James Holland

18. Mother's Name (First, Middle, Maiden Surname): Loulla Walker

19a. Informent's Name/Relationship (Type, Print): James Holland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 66 Culver St. Balt. MD. 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem. Date: 1/9/97

20c. Location - City or Town, State: Laurel MD.

21. Signature of Funeral Service Licensee: Gary F. Marsh

22. Name and Address of Facility: Gary F. Marsh Funeral Home P.A. 270 Friendship Pass Balt. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY DISTRESS SYNDROME — 12/28/96

Due to (or as a consequence of):

b. HEMOLYTIC ANEMIA — 12/29/96

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ACQUIRED IMMUNODEFICIENCY SYNDROME

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Getachew

29c. Licansa number: D42804

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Asresahegn Getachew, P.O. Box 977, Jessup, MD, 20794

State Registrar

31. Date filed (Month, Day, Yeer): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: When a certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY H. HOWARD
2. Date of Death (Month, Day, Year): January 3, 1997
3. Time of Death: 11:00pm
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-20-8544
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
6. Date of Birth (Month, Day, Year): Aug. 21 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Pikesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 210 Church Lane
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Saftey/Maintanence
16b. Kind of Business/Industry: Eastern Greyhound

17. Father's Name (First, Middle, Last): Samuel P. Howard
16. Mother's Name (First, Middle, Maiden Surname): Edna Fleagle

19a. Informant's Name/Relationship (Type, Print): Frederick Howard/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 210 Church Lane Pikesville, Md. 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 1-6-97
20c. Location - City or Town, State: Pikesville,Md.

21. Signature of Funeral Service Licensee: ▶ Kendall Faulkner
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CANCER OF TONGUE — 18 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER - STOMACH METASTASES

ALZHEIMER'S DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
26b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kendall Faulkner
29c. License number: D25643
29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24-hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00201

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Effie Marie Hayes
2. Dete of Deeth — Month: January; Day: 6; Yeer: 1997
3. Time of Death: 02:15
4e. Fecility Neme *(If not institution, give street and number)*: Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-14-8156
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: June 20, 1919
9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 7758 Gough Street
10f. Zip Code: 21224
10g. Citizen of Whet Country?: United States

11. Merifel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Unknown Buchman
18. Mother's Neme *(First, Middle, Maiden Surname)*: Charlotte Murray

19e. Informent's Neme/Reletionship *(Type, Print)*: CharlotteM. Knotts Daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7758 Gough Street Baltimore, MD 21224

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery
Dete: 1/10/97
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: ▶ Milton J. Knight
22. Neme end Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immedlete Ceuse (Finel diseese or condition resulting in deeth) e.	Ruptured Abdominal Aortic Aneurysm	2hours
Due to (or as a consequence of):		
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last b.	Atherosclerosis	10 years
Due fo (or es e consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part ii. **Other significant conditions** contributing fo death but not resulting in the underlying ceuse given in Pert i.: COPD,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the fime, dete end plece, and due fo the cause(s) end manner steted.

29b. Signeture and title of certifier: ▶ Michael Harper, MD
29c. License number: D43732
29d. Dete signed *(Month, Day, Year)*: January 6, 1997

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Michael Harper, MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 0 8 1997
32. Registrar's Signeture: ▶ Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00202

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marion D. Harden

2. Deta of Death Month Day Year: Jan. 4, 1997

3. Time of Death: 4:00 AM

4a. Facility Name *(If not institution, give street and number)*: Manor Care

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 188-32-1042

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 30, 1907

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2501 Musgroue Rd.

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nutritionist

16b. Kind of Business/Industry: Food Service

17. Father's Name *(First, Middle, Last)*: Robert C. Douds

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary I. Boal

19a. Informant's Neme/Reiationship *(Type, Print)*: Mr. Robert Harden (son)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9458 Two Hills Ct. Columbia, Md. 21045

20a. Method of Disposition: 1☐ Buriai 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Greenmount Crematory

Date: 1/7/97

20c. Location - City or Town, Stata: Balto. Md.

21. Signatura of Funerai Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that ceused the death. Do not entar tha mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one cause on each lina.

Approximaia Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or es e consequence of):

Sequentieily list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Seizures

23b. Did tobacco use contribute to the causes of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceusa of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piace, end due to the ceuse(s) and manner stated.

29b. Signatura and tiia of certifiar: Jenny Y Moy

29c. Licensa number: D43260

29d. Data signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Jenny Y Moy, MD 14333 Laurel Bowie Rd #307 Laurel MD 20708

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Julia Davidson-Rondell

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00203

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Hightower

2. Date of Death — Month: Jan Day: 6 Year: 97

3. Time of Death: 550 Am

4a. Facility Name *(If not institution, give street and number)*: Liberty Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-28-4269

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Oct. 23, 1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4805 Beaufort Ave.

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 8

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Theophilos Aiken

18. Mother's Name *(First, Middle, Maiden Surname)*: Mattie Manokey

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Vanessa Hightower (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4805 Beaufort Ave. Balto. Md. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion

Date: 1/10/97

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction — Due to (or as a consequence of): — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Anemia — Due to (or as a consequence of): — unknown

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia

chronic obstructive pulmonary disease

Diabetes Mellitus - Obesity

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible], M.D.

29c. License number: D33583

29d. Date signed *(Month, Day, Year)*: Jan 6 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hafez Zreberg, M.D. LMC 2600 Liberty Heights Ave Baltimore, Md 21215

To the Physician - Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LLOYD HARRISON
2. Date of Death Month Day Year: JANUARY 5 1997
3. Time of Death: 3:46 AM
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL & MEDICAL CENTER
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-12-5502
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1924
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street and Number: 640 N. Centre Street
10f. Zip Code: 21502
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942 - 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Municipal worker
16b. Kind of Business/Industry: government

17. Father's Name (First, Middle, Last): Lloyd Edward Harrison JR.
18. Mother's Name (First, Middle, Maiden Surname): Nellie Harrison Taylor Hager

19a. Informant's Name/Relationship (Type, Print): Kathy Kinsman/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 307 Arch St., Cumberland, MD 21502

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 4 WEEKS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ISCHEMIC CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Lamm MD
29c. License number: D 25406
29d. Date signed (Month, Day, Year): JANUARY 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM LAMM M.D., 47 VIRGINIA AVENUE, CUMBERLAND, MD 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: Julia Davidson-Kendall

DHMH 16 Rev 6/95

97 00205

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES, HAWKINS
2. DATE OF DEATH (Month, Day, Year): 01 05 97
3. TIME OF DEATH: 0440 M
4. SOCIAL SECURITY NUMBER: 219-32-4766
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-7-36
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): EASTERN CORRECTIONAL INST
9b. CITY, TOWN OR LOCATION OF DEATH: WESTOVER, MD
9c. COUNTY OF DEATH: SOMMERSET

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Somerset
10c. CITY, TOWN OR LOCATION: Westover
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: E.C.I. Inst.
10f. ZIP CODE: 21853
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Industrial
17. FATHER'S NAME (First, Middle, Last): Willard H. Hawkins
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): E.C.I. Inst.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): C/o P.O. Westover Md. 21853
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) — DATE
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Shirley E. Ward
22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, 655 W. Baltimore St/ 30639 Hampden Ave Princess Anne Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	TERMINAL LUNG CANCER	>1 YEAR
DUE TO (OR AS A CONSEQUENCE OF): b.		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.	TERMINAL LUNG CANCER	>1 YEAR

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) ECI
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D50826
29d. DATE SIGNED (Month, Day, Year): 1/7/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAZAAIC. A. ENIOLA. PRISON HEALTH SERVICES, ECI, WESTOVER MD 21890
31. DATE FILED (Month, Day, Year): JAN 08 1997
32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William E. Justice, Jr.

2. Date of Death: Month January Day 5, Year 1997

3. Time of Death: 12 :45 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-07-3955

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 26, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Eastwood

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 509 Fairview Avenue

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembler

16b. Kind of Business/Industry: General Motors

17. Father's Name (First, Middle, Last): William E. Justice, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Carrie E. Brashers

19a. Informent's Name/Relationship (Type, Print): Rosemarie Hastings (Daughter)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Eastship Rd. Dundalk, Md. 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other placa): Oak Lawn Cemetery

Dete: 1/8/1997

20c. Location - City or Town, State: Baltimore Co. Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. 21221

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in death)
a. Acute myocardial infarct. — hours.

Due to (or as a consequence of):
b. C.A.D.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or as a consequenca of):
c. A.S.C.V.D.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

C.V.A.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piace of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☒ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica builiding, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) and menner as steted. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], M.D.

29c. License number: D02191

29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATAOLLAH GOLPIRA, M.D. 3029 Dundalk ave. Baltimore, Md. 21222

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

12

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Orville James Jones

2. Date of Death Month Day Year: January 5, 1997

3. Time of Death: 10:05 P.M.

4a. Facility Name (If not institution, give street and number): Manor Care Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 216-14-4605

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 28, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3807 White Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician

16b. Kind of Business/Industry: Typewriter Repair Company

17. Father's Name (First, Middle, Last): Birdie Columbus Jones

18. Mother's Name (First, Middle, Maiden Surname): Addie May Unknown

19a. Informant's Name/Relationship (Type, Print): Margaret Pinkowski Jones/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3807 White Avenue, Baltimore, Maryland 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 1/8/1997

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASCVD — 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gail W. Miller, MD

29c. License number: D22719

29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GAIL W. MILLER, MD 9506 Harford Rd, Balt. MD 21234

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH M. JENDRICK

2. Date of Death Month: JAN Day: 5 Year: 97

3. Time of Death: 5AM

4a. Facility Name (If not institution, give street and number): 807 PLATINUM AVE

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215 189414

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 8, 1911

9. Birthplace (State or Foreign Country): WestVirginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 807 Platinum Ave.

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector

16b. Kind of Business/Industry: Crown Cork & Seal

17. Father's Name (First, Middle, Last): Joseph Jendrick

18. Mother's Name (First, Middle, Maiden Surname): Hanna Czeto

19a. Informant's Name/Relationship (Type, Print): Irene E. McLaughlin/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 East Lee Street Baltimore Md. 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, other place): Moreland Memorial Cemetery

Date: 1/7/97

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PEMPHIGUS VULGARIS — 5 Mo

Due to (or as a consequence of):
b. MASSIVE PREDNISONE Rx

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year) —

28b. Time of Injury — M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred —

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —

28f. Location (Street and Number or Rural Route Number, City or Town, State) —

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph S McLaughlin

29c. License number: D-8197

29d. Date signed (Month, Day, Year): JAN 5 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph S McLAUGHLIN Univ Hosp BALTIMORE Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Gilda Davidson-Ponder

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Film G743 item 10a,5d per FH 1-8-97 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Jendras

2. Date of Death: Month 01 Day 05 Year 97

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS GERIATRIC CENTER 5505 Bayview Circle

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-05-~~3348~~ 5343

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-24-01

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: ~~Maryland~~

10b. County: BALTIMORE

10c. City, Town or Location: Dundalk

10d. Inside City Limits: ~~1☒~~ Yes 2☒ No

10e. Street and Number: 6615 Danville Avneue

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years; College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lawrence Waurzyniak

18. Mother's Name (First, Middle, Maiden Surname): Frances Gorolski

19a. Informant's Name/Relationship (Type, Print): Lawrence Jendras, Sr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6617 Danville Avenue Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Oak Lawn Cemetery

Date: 01/08/1997

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	congestive Heart Failure	one week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	upper respiratory infection	one week
Due to (or as a consequence of):		
c.	delirium	one week
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Coronary Artery Disease, History of Volvulus, Total Hip replacement, osteoporosis, Heel decubitus ulcer.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan Zieman, MD

29c. License number: D50701

29d. Date signed (Month, Day, Year): January 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN ZIEMAN 5505 BAYVIEW CIRCLE BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00210

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALICE LANCASTER KELLY
2. Date of Death Month / Day / Year: JANUARY 4, 1997
3. Time of Death: 3:15 P.M.
4a. Facility Name *(If not institution, give street and number)*: 13430 LONG GREEN PIKE
4b. City, Town, or Location of Death: HYDES
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-18-4400
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUGUST 30, 1917
9. Birthplace *(State or Foreign Country)*: FALLSTON, MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: HYDES
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13430 LONG GREEN PIKE
10f. Zip Code: 21082
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOUSEKEEPING-OWN HOME

17. Father's Name *(First, Middle, Last)*: WILLIAM AARON LANCASTER
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY ELLEN HANLON

19a. Informant's Name/Relationship *(Type, Print)*: AARON B. KELLY (SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13428 LONG GREEN PIKE HYDES, MARYLAND 21082

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. JOHN'S LONG GREEN CEM. — Date: JANUARY 7,1997
20c. Location - City or Town, State: LONG GREEN, MARYLAND

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: E.F. LASSAHN FUNERAL HOME, P.A. 11750 BELAIR ROAD KINGSVILLE, MARYLAND 21087-1351

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiorespiratory Arrest
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: D20637
29d. Date signed *(Month, Day, Year)*: 1-6-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 65 G N. Charles Street, Baltimore, Md. 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00211

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Ruth Lorraine Kentner
2. Dete of Deeth: Month January Dey 6 Year 1997
3. Time of Deeth: 11:45 PM
4e. Facility Neme (If not institution, give street end number): 2418 Eugene Avenue
4b. City, Town, or Location of Deeth: Edgemere
4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 219-10-3930
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Oct. 27, 1925
9. Birthpiece (Stete or Foreign Country): Massachusetts

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2418 Eugene Avenue
10f. Zip Code: 21219
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6 Years | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Raymond Leroy Maddox
18. Mother's Name (First, Middle, Meiden Surneme): Margaret Josephine Owens

19e. Informent's Neme/Relationship (Type, Print): Husband Mr. Henry C. Kentner, Jr.
19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2418 Eugene Ave. Edgemere, Maryland 21219

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetary, cremetory or other piece): Gardens of Faith Cem. | Date: 01/10/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funerel Service Licensee: [signature]
22. Neme end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line. (Approximete Interval Between Onset end Death)

Immediete Ceusa (Finel disease or condition resulting in deeth)
a. Metastatic Small Cell CA
Due to (or as e consequence of):
Sequentielly list conditions, if any, leeding to Immediete causa. Enter Underlying Ceuse (Disaesa or injury thet initiated events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other sfgnificant conditions** contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Mennar of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of fnjury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physicfan**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceusa(s) and mennar as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) end mennar stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D26835
29d. Dete signed (Month, Day, Year): 1-7-97
30. Neme end eddress of person who completed causa of deeth (Item 23a) (Type, Print): Paul Valle MD 1012 Old N. Pt. Rd. 21224

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 08 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00212

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Morris Kinnersley, Jr.

2. Dete of Deeth: Month January Dey 3 Yeer 1997

3. Time of Death: 12:05 pm

4e. Feclity Name (If not institution, give street end number): Bayview Medical Center

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 216-03-1307

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): January 5, 1909

9. Birthpleca (Stete or Foreign Country): Maryland

Usuel Residence of Decedant

10e. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 8800 Walther Boulevard Apt. 2101

10f. Zip Code: 21234

10g. Citizan of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Year or Dates: WW II

13. Was Dacedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12) / College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Tax Collector

18b. Kind of Business/Industry: City of Baltimore

17. Father's Neme (First, Middle, Last): William M. Kinnersley, Sr.

18. Mother's Name (First, Middle, Meiden Surneme): Catherine E. Schrieber

19e. Informent's Neme/Reletionship (Type, Print): Mrs. Mildred W. Kinnersley / Wife

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8800 Walther Blvd. Apt. 2101 Parkville,Md. 21234

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cramatory or othar piece): Hilltop Service Corporation

Date: 1/6/97

20c. Location - City or Town, State: Towson, Maryland

21. Signeture of Funerel Servica Licensee: Mark T. Zavoyna ▶ Mark T. Zavoyna

22. Neme and Address of Fecility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

immediete Ceuse (Finel disease or condition resulting in deeth)

a. Pneumonia — Weeks

Due to (or as e consequenca of):

Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did **tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to compleiion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end dua to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner statad.

29b. Signeture end title of certifier: ▶ Myla M Carpenter MD

29c. License number: D 30989

29d. Dete signed (Month, Day, Year): Jan 04 1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Myla M Carpenter, MD 711 Maiden Choice Ln Baltimore MD

State Registrar

31. Dete filed (Month, Day, Year): JAN 0 8 1997

32. Registrer's Signeture: Julia Tarkson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James H. LOVE, Jr.

2. Date of Death (Month, Day, Year): January 4, 1997

3. Time of Death: 2:55 Am

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-42-3997

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 17, 1945

9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 724 Riverside Dr.

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Millwright

16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): James H. Love, Sr.

18. Mother's Name (First, Middle, Meiden Surneme): Mary Jean Moyer

19a. Informent's Neme/Relationship (Type, Print): Wanda L. Love - Wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 724 Riverside Dr. Essex, Maryland 21221

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: Jan 6, 1997

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Thad W. Tasky

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): e. Chronic obstructive pulmonary disease — 2 years

Due to (or as a consequence of): Asbestosis

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last:

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditfons contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicfan:** To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Anthony Guarino, MD

29c. License number: D46673

29d. Dete signed (Month, Day, Year): January 4, 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Anthony Guarino MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 0 8 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6 of 1

97-0100-510
CMK ITEMS: 23 PART I, 27, 28a-f,
PER MEO FILM g-743 1/14/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00214

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ERNEST LATTIMORE
2. Date of Death (Month, Day, Year): JANUARY 05, 1997
3. Time of Death: 2135PM
4a. Facility Name *(If not institution, give street and number)*: 2417 WEST LANVALE STREET
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/a

Funeral Director

5. Social Security Number: 217-96-5434
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 41 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04/6/55
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2417 WEST LANVALE STREET
10f. Zip Code: 21216
10g. Citizen of What Country?: u.s.a.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK
16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name *(First, Middle, Last)*: ERNEST LATTIMORE
18. Mother's Name *(First, Middle, Maiden Surname)*: GLADYS ROBINSON

19a. Informant's Name/Relationship *(Type, Print)*: GLADYS LATTIMORE(MOTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1015 KENWOOD AVE. BALTO.,MD 21205

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEM. PARK — Date: 1/10/97
20c. Location - City or Town, State: RANDALLSTOWN,MD.
21. Signature of Funeral Service Licensee: Loretta Heath CFSP #291
22. Name and Address of Facility: E.L. PHILLIPS FUNERAL HM 1721-27 MONROE STREET BALTO.,MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending investigation 6 ☒ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: FOUND: 1-5-97
28b. Time of Injury: FOUND 9:20 P M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: FOUND: RESIDENCE
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 2417 W. LANVALE STREET BALTIMORE, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Marjorie Bothell
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JANUARY 06, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARJORIE A. BOTHELL M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00215

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHAWN LANCE

2. Date of Death — Month: 01 Day: 05 Year: 1997

3. Time of Death: 900 AM

4a. Facility Name *(If not institution, give street and number)*: SPRING GROVE HOSPITAL CTR.

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 167-42-9200

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 18, 1950

9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: [X] 1 Yes [ ] 2 No

10e. Street and Number: Wade Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown — 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [ ] 1 Yes [ ] 2 No — If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): [ ] 1 Yes [ ] 2 No *Specify:* unknown

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Interment's Name/Relationship *(Type, Print)*: unknown

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: [ ] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [X] 5 Other *(Specify)* in-state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CORONARY ARTERY DISEASE — SINCE 02/86

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [✓] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [✓] 2 No

24b. Were autopsy findings available prior to completion of cause of death? N/A [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [✓] 2 No

26. Place of Death *(Check only one)*: Hospital: [✓] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA — Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other *(Specify)*

27. Manner of Death: [✓] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*: N/A

28b. Time of Injury: N/A M

28c. Injury at Work? N/A [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: N/A

29a. Certifier *(Check only one)*: [✓] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Junaid Muhammad Ghadai m.o.

29c. License number: D47002

29d. Date signed *(Month, Day, Year)*: 01/05/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUNAID MUHAMMAD GHADAI M.O. SPRING GROVE HOSP. CTR. CATONSVILLE MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ITEMS: 4c,9,10b, 12-22 PER F.H.
FILM g-743 1/14/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daisy Laurey
2. Date of Death Month Day Year: January 3, 1997
3. Time of Death: 14:18
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-64-2170
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 15, 1954
9. Birthplace (State or Foreign Country): ~~unknown~~ NORTH CAROLINA

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3711 W. Garrison Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: ~~unknown~~
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No ~~unknown~~ Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): ~~unknown~~ 9
College (1-4or 5+): ~~unknown~~ N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ~~unknown~~ DOMESTIC
16b. Kind of Business/Industry: ~~unknown~~ HOMEMAKER

17. Father's Name (First, Middle, Last): ~~unknown~~ FREDDIE LAUREY
18. Mother's Name (First, Middle, Maiden Surname): ~~unknown~~ VICTORIA STEPHENSON

19a. Informant's Name/Relationship (Type, Print): VICTORIA S. SULLIVAN-MOTHER ~~unknown~~
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~unknown~~ 1325 PRESSTMAN ST. BALTIMORE, MD. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) ~~in state~~
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 1-11-97
20c. Location - City or Town, State: LANSDOWNE, MD.

21. Signature of Funeral Service Licensee: JOSEPH R. WALTERS ~~Ronald S. Wade, Director~~
22. Name and Address of Facility: UNITY FUNERAL HOME 108 W. NORTH AVE. ~~State Anatomy Board, 655 W. Baltimore Street~~ Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia
Due to (or as a consequence of):
b. Renal Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Severe Metabolic Acidosis
Due to (or as a consequence of):
d. Aquired Immunodeficiency Syndrome

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. BAUTISTA
29c. License number: 89233
29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ARWIDNAH Bautista, M.D. C/O MARYLAND GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Linda Madison-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00217

Physician /Medical Examiner

1. Decadant's Name *(First, Middla, Last)*: John Lynch

2. Date of Deeth — Month: Jan Day: 06 Yaar: 1997

3. Tima of Death: 3:50 AM

4a. Faciiity Nema *(If not institution, give street end number)*: Lorien Nursing & Rehab Center

4b. City, Town, or Location of Deeth: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Numbar: 578-52-6227

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: 82 Yrs.

If Undar 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Dey, Year)*: July 14, 1914

9. Birthplace *(Stete or Foraign Country)*: Maryland

Usual Rasidanca of Decadant

10a. Steta: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Straat and Number: 11115 Willow Bottom Drive

10f. Zip Coda: 21044

10g. Citizan of Whet Country?: USA

11. Maritei Status: 1 [ ] Naver Married 2 [X] Marriad 3 [ ] Widowad 4 [ ] Divorcad

12. Was Decedent Evar in U.S. Armad Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaar or Datas: 1932 1954

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bieck, White, etc. *Specify:* White

15. Decedant's Education *(Spacify only highest grada completed)*: Elemantery/Secondery (0-12): 12 College (1-4or 5+): 7

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Assoc. Dir. Naval Invest. Svc.

16b. Kind of Businass/Industry: US Government

17. Fethar's Name *(First, Middla, Last)*: William J. Lynch

18. Mothar's Nama *(First, Middle, Maidan Sumema)*: Gertrude E. Andrews

19a. Informant's Name/Reletionship *(Typa, Print)*: Frances M.Lynch/Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: 11115 Willow Bottom Drive, Columbia, Maryland 21044

20e. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar *(Spacify)*

20b. Place of Disposition *(Name of cemetary, cramatory or othar place)*: Arlington National Cem.

Data: 1/13

20c. Location - City or Town, Stata: Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Batween Onset and Death

Immediate Ceusa (Final disaasa or condition resulting in daath)
e. Congestive Heart failure — 2 mos

Due to (or as a consequance of):
b. coronary artery disease — 3 mos

Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaase or injury thet initiated avants resulting in death) Last
Due to (or es e consequanca of):
c.
Due to (or es a consaquance of):
d.

Part ii. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Hypertension

chronic renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availeble prior to compiation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa refarrad to medical axaminer? 1 [ ] Yes 2 [X] No

28. Placa of Daath *(Check only ona)*: Hospital: 1 [ ] inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [X] Nursing Homa 5 [ ] Rasidance 8 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Naturei 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be determined

28a. Data of injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29e. Certifiar *(Check only one)*: 1 [X] **Certifying Physician:** To the bast of my knowiedge, deeth occurred at tha time, deta and place, end dua to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha time, dete end piace, and dua to tha cause(s) and manner stated.

29b. Signatura and title of certifiar: Thomas J Russi MD

29c. Licansa number: D50785

29d. Data signed *(Month, Dey, Year)*: JAN 06, 1997

30. Nama and address of person who complatad causa of death (item 23a) (Type, Print): Thomas J Russi, MD 10805 thickory Ridge Rd Columbia MD

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Madison-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

36+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Marie	L.	Martin	January 6, 1997	8:35 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 14 0142	1☐ M 2☒ F	84 Yrs.			Feb. 13, 1912	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	n/a	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4813 Claybury Ave.	21206	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Winkel	Marie Guinan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan Cutson / daughter	4813 Claybury Ave., Baltimore, MD 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Green Mount Crematory	1/11/97	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen D Lohrmann	CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	one week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Spontaneous Bacterial Peritonitis	one week
Due to (or as a consequence of):		
	c. Liver Masses and Hepatic failure	unknown
Due to (or as a consequence of):		
	d. Pelvic Mass	unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Michael Westerman, M.D.	96121	January 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Michael Westerman, M.D.	Johns Hopkins Bayview Medical Center 4940 Eastern Avenue, Baltimore, MD 21224

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 08 1997	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00219

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther V. Monahan

2. Date of Death: Month Jan. Day 6 Year 1997

3. Time of Death: 7:00 p.m.

4a. Facility Name (If not institution, give street and number): 7635 Bay Street

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 246-24-8492

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 6, 1924

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: PASADENA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7635 BAY STREET

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROPRIETOR

16b. Kind of Business/Industry: TAVERN

17. Father's Name (First, Middle, Last): WILLIAM LOVETTE

18. Mother's Name (First, Middle, Maiden Surname): BETTY HUDSON

19a. Informant's Name/Relationship (Type, Print): E.Jo-Anne Monahan daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7635 Bay St. Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN CEMETERY Date: JAN. 9 /97

20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Hilary C. Stallings Jr.

22. Name and Address of Facility: STALLINGS FUNERA HOME P.A. 3111 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lung cancer — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Gillison MD

29c. License number: P07127

29d. Date signed (Month, Day, Year): January 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Maura Gillison 600 N. Wolfe Street

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997

32. Registrar's Signature: ▶ Phyllis Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00220

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVELYN MAY MCLEAN

2. Date of Death Month / Day / Year: JANUARY 6 1997

3. Time of Death: 6:40 P.M.

4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-18-8772

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 4, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 36 Wiltshire Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10 | College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: House Wife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Lest)*: Harry Bush

18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Denny

19a. Informant's Name/Relationship *(Type, Print)*: Charles Robert McLean, Jr. (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6521 Blackhead Rd. Middle River, Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Gardens Of Faith Cemetery Date: 1/9/1997

20c. Location - City or Town, State: Baltimore Co., Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy Low, M.D.

29c. License number: D24034

29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TIMOTHY LOW, M.D 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

15

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward I. McKenna, Jr.

2. Date of Death: Month January Day 5, Year 1997

3. Time of Death: 0840

4a. Facility Name (If not institution, give street and number): 425 Pembrooke Blvd.

4b. City, Town, or Location of Death: Eastwood

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219 22 4686

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 11, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Eastwood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 425 Pembrooke Blvd.

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1950-52

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tractor Operator

16b. Kind of Business/Industry: Can Company

17. Father's Name (First, Middle, Last): Edward I. McKenna, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ethel Bright

19a. Informant's Name/Relationship (Type, Print): Bruce J. Chaillou (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Fuselage Ave. Essex, Maryland 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery | Date: Jan. 8, 1997

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home PA
1407 Old Eastern Ave. Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic ischemic myocardial disease — 2 years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Crossan O'Donovan, M.D.

29c. License number: D07632

29d. Date signed (Month, Day, Year): January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CROSSAN O'DONOVAN, M.D. 2112 DUNDALK AVE BALTO MD 21222

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Ic + VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine MITCHELL
2. Date of Death (Month, Day, Year): January 4, 1997
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: n/a
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 240-80-0280
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 17, 1921
9. Birthplace (State or Foreign Country): COVE, N.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1715 HARLEM AVENUE
10f. Zip Code: 21217
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EVANGELIST
16b. Kind of Business/Industry: HOLY HOUSE of PRAYER

17. Father's Name (First, Middle, Last): WALTER DUNN
18. Mother's Name (First, Middle, Maiden Surname): JANIE BROWN

19a. Informant's Neme/Relationship (Type, Print): PEGGY MITCHELL
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1715 HARLEM AVENUE, BALTIMORE, MD# 17

20a. Method of Disposition: 1☒ Burial 2☐ Cremelion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): VETERAN CEMETERY
Date: ship
20c. Location - City or Town, State: NEWBERN, N.CAROLINA

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: WM. C. MARCH FH.-1101 E. NORTH AVENUE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arresl, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condilion resulting in death)	a. End Stage Renal Disease	4 Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Type II Diabetes Mellitus	
	Due to (or as a consequence of):	
	c. Hypertension	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple Brain Infarctions

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or Investigetion, In my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Signature end title of certifier: Katherine Hatmaker DO
29c. License number: RD#1914
29d. Date signed (Month, Day, Year): 1/4/97

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Katherine Hatmaker DO. 9000 Franklin Square Dr. Balto, Md. 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00223

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norman Russell MACNEAL

2. Data of Daath — Month: January Day: 7, Yaar: 1997

3. Tima of Death: 5:35 am

4a. Facility Nama *(If not institution, giva street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Sacurity Number: 217-09-7320

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Feb.14,1920

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residance of Dacedani

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 1947 Holborn Rd.

10f. Zip Coda: 21222

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Marriad 3 [ ] Widowed 4 [ ] Divorcad

12. Was Dacedant Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decadant's Educetion *(Spacify only highest grada complatad)*: Elamantary/Secondery (0-12): 10 yrs. / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa ratired)*: Chauffeur

16b. Kind of Businass/Industry: Esskay

17. Father's Name *(First, Middle, Lest)*: William Macneal

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Elma Linthicume

19e. Informant's Name/Ralationship *(Type, Print)*: Kathleen Macneal wife

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1947 Holborn Rd. Dundalk Md. 21222

20a. Method of Disposition: [X] 1 Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar place)*: Gardens Of Faith

Data: 1-10

20c. Location - City or Town, State: Rossville

21. Signature of Funaral Service Licensee: John E Connelly

22. Nama and Addrass of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications thet causad tha daath. Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heert feilura. List only one ceuse on aach line.

Approximeta Intervel Between Onsat and Deeth

Immediate Ceuse (Finel disaasa or condition resulting in daath)

e. Pneumonia — 1 Week

Dua to (or as a consequance of):

Saquantially list conditions, if any, laading to immadiata ceusa. Enlar Undarlying Causa (Disaase or Injury that initiated events rasulting in daath) Last

b. Chronic Obstructive Pulmonary Disease — 10 Years

Dua to (or as a consequance of):

c.

Dua to (or es a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to completion of ceuse of death? 1 [ ] Yas 2 [ ] No

25. Was cese refarred to medical exeminar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only one)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be datarmined

28a. Date of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Plece of Injury - At home, farm, street, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledga, death occurred at tha time, date end plece, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to tha causa(s) and mannar statad.

29b. Signatura and litle of certifiar: Mary E Craig MD

29c. Licansa number: RD2106

29d. Data signed *(Month, Day, Yaar)*: 1/7/97

30. Nama and address of person who completed ceusa of daath (Itam 23a) (Typa, Print): Mary E. Craig M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 08 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Byron Ray McLean
2. Date of Death Month Jan. Day 6, Year 1997
3. Time of Death: 7:20 PM
4a. Facility Name (If not institution, give street and number): Good Samaritan Nursing Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-03-1207
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 7, 1913
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1839 Portship Road
10f. Zip Code: 21222
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Metalergist
16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Joseph McLean
18. Mother's Name (First, Middle, Maiden Surname): Minnie Ray

19a. Informant's Name/Relationship (Type, Print): Ms. Alma L. McLean/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4328 Brehms Lane Baltimore, Maryland 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 01/08/1997
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Cardiopulmonary Arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anaplastic Thyroid Cancer; Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: ▶ [signature]
29c. License number: D43725
29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Tariq Mahmood M.D. 201 Back River Neck Road Essex, Maryland 21221

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 00225

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Claude C. MEise			2. DATE OF DEATH: MONTH 1 DAY 3 YEAR 97	3. TIME OF DEATH: 10:55 AM
4. SOCIAL SECURITY NUMBER: 212-07-7027	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-04-13	8. BIRTHPLACE (State or Foreign Country): Baltimore, Md.
9a. FACILITY NAME (If not institution, give street and number): Genesis Eldercare Cromwell CTR.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Kingsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 902 Monica Circle		10f. ZIP CODE: 21087	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th. College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer	16b. KIND OF BUSINESS/INDUSTRY: Glen L. Martin	
17. FATHER'S NAME (First, Middle, Last): Lawrence Meise		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara C. Baier	
19a. INFORMANT'S NAME (Type/Print): Mrs. Sadie M. Meise (Wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 902 Monica Circle Kingsville, Md. 21087	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): St. Michael Luth. Church Cem. DATE: Jan. 7, 1997	20c. LOCATION — City or Town, State: Perry Hall, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: E. F. Lassahn Funeral Home		22. NAME AND ADDRESS OF FACILITY: E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia — 1 week

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. COPD

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- CAD
- Alzheimer Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D24276	29d. DATE SIGNED (Month, Day, Year): 1-3-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Simon V Scalia 2801 Hudson St		
31. DATE FILED (Month, Day, Year): JAN 08 1997	32. REGISTRAR'S SIGNATURE: Giulia Davidson-Randall	

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES MCLERNON

2. Date of Death (Month, Day, Year): JANUARY 5, 1997

3. Time of Death: 5:02 PM

4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-12-0952

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/03/1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 102 Swarthmore Drive Apt. F

10f. Zip Code: 21204

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Cemetery

17. Father's Name (First, Middle, Last): James McLernon

18. Mother's Name (First, Middle, Maiden Surname): Edith Compton

19a. Informant's Neme/Relationship (Type, Print): Virginia McLernon/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 Swarthmore Dr. Apt. F Towson, Maryland 21204

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Dulaney Valley Mem. Gards. Date: 01/08/97

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Michael J. Ruck Jr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RENAL FAILURE	1 WK
Due to (or as a consequence of): b.	PERITONITIS	2 WKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	PERFORATED VISCUS	2 WKS.
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CIRRHOSIS OF LIVER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Kleeman

29c. License number: D16501

29d. Date signed (Month, Day, Year): 1.7.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES KLEEMAN, M.D., 7505 OSLER DRIVE, S-502, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Judith Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

1 of 1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM D. NORRIS

2. Date of Death Month JAN Day 4 Year 1997

3. Time of Death 1400HRS

4a. Facility Name (If not Institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-36-1413

6. Sex 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): JUNE 25, 1938

9. Birthplaca (State or Foreign Country): MARYLAND

Usual Residenca of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits 1 [X] Yas 2 [ ] No

10e. Street and Number: 2708 WILKENS AVE

10f. Zip Code: 21223

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Datas:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK

16b. Kind of Business/Industry: CITY GOVERNMENT

17. Father's Name (First, Middle, Last): WILLIAM D. NORRIS, SR

18. Mother's Name (First, Middle, Maidan Surname): GERTRUDE E. STEFFEE

19a. Inlorment's Name/Relationship (Type, Print): WILLIAM THOMAS/STEPSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2907 KINGSLEY ST. BALTIMORE, MD 21223

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: 1/8/97

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensea: Anthony S. DiMeo

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVE BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart lailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)

a. LIVER FAILURE DUE TO CHRONIC ALCOHOLISM — 20 YEARS

Due to (or as a consequence of):

b. DIABETES MELITUS — 10 YEARS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yaa 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese relerred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) end manner stated.

29b. Signature and title of certifier: BERNADETTE BONAPARTE M.D

29c. License number: P09140

29d. Date signed (Month, Day, Year): JAN 07 1997

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): BERNADETTE BONAPARTE ST. AGNES HEALTHCARE BALTIMORE

State Registrar

31. Dete filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00228

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Powell

2. Date of Death — Month: JANUARY Day: 3 Year: 1997

3. Time of Death: 1708

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 314-16-9467

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: May 1, 1919

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2210 Stryker Ct.

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4 or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Thomas Gilpin Johnston

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Robertson

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Richard Powell/husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2210 Stryker Ct. Lutherville, Md. 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp. Date: 1/6/97

20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 3 days

Due to (or as a consequence of):

b. Subarachnoid Hemorrhage — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Cerebral Aneurysm — 2 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Resident Physician

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: January 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Kevin A. Walter, 600 N. Wolfe St., Baltimore, MD 21287

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine L Rodgers
2. Date of Death Month: January Day: 6, Year: 1997
3. Time of Death: 8:30 AM
4a. Facility Name (If not institution, give street end number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-16-0903
8. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 4 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1621 MORELAND AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: PRIVATE family

17. Father's Name (First, Middle, Last): JAMES NEALE
18. Mother's Name (First, Middle, Malden Surname): MARTHA

19a. Informant's Name/Reletionship (Type, Print): Catherine Hawkins, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1621 MORELAND AVE BALTIMORE, MARYLAND 21216

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 1/13/97
20c. Location - City or Town, Stete: BALTIMORE, Maryland

21. Signature of Funeral Service Licensee: Henry Harris
22. Name end Address of Facility: CHAPMAN - HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. Pneumonia

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Chronic Pulmonary Obstructive Disease
Due to (or as a consequence of):
c. Respiratory failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G. Dazth MD MEDICAL HOUSE OFFICER
29c. License number: 89269
29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Gervacio Diaz, M.D. 40 Maryland General Hospital.

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00230

tem: 5, per F.H. G-744 2/24/97 reb

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH RUPRECHT
2. Date of Death Month JANUARY Day 6, Year 1997
3. Time of Death: 15 25
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-46-6339 ~~217-47-6339~~
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 28, 1946
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Clarksville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11308 Old Hopkins Rd.
10f. Zip Code: 21029
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Safety Manager
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Joseph Daniel Ruprecht
18. Mother's Name (First, Middle, Maiden Surname): Rosette Anselmo

19a. Informant's Name/Relationship (Type, Print): Barbara A. Ruprecht / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11308 Old Hopkins Rd., Clarksville, MD 21029

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 1/8/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Glioblastoma Multiforme — 8 months
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD PhD
29c. License number: M3695
29d. Date signed (Month, Day, Year): January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Pathology 509, Johns Hopkins Hospital, Baltimore MD 21205, Michael Wang MD, PhD

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0056-005
C.I.P

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00231

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth Albert Ross
2. Date of Death Month Day Year: January 4, 1997
3. Time of Death: 06:09
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital E.R
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-52-8469
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DECEMBER 7, 1950
9. Birthplace *(State or Foreign Country)*: BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE COUNTY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5431 CYNTHIA TERRACE
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Year or Dates: VIETNAM
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPET INSTALLER
16b. Kind of Business/Industry: A & B FLOORING

17. Father's Name *(First, Middle, Last)*: CONRAD HOWARD ROSS
18. Mother's Name *(First, Middle, Maiden Surname)*: THERESA HELEN ZORN

19a. Informant's Name/Relationship *(Type, Print)*: DEBORAH C. ROSS (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5431 CYNTHIA TERRACE BALTIMORE, MARYLAND 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ZION CEMETERY JANUARY 8, 1997
Date:
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Heather Lassahn
22. Name and Address of Facility: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jason Locke MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 4, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAWRENCE LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilbert F Rohleder

2. Date of Death: Month 01 Day 04 Year 1997

3. Time of Death: 12:21 pm

4a. Facility Name (If not institution, give street and number): Church Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-01-8769

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05/22/13

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2535 Eastern Avenue

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician

16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): Harry F. Rohleder

18. Mother's Name (First, Middle, Maiden Surname): Lillian M. Buck

19a. Informant's Name/Relationship (Type, Print): Herbert H. Rohleder/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2535 Eastern Avenue, Baltimore, Maryland 21224

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery Date: 1/9/1997

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	10days
Due to (or as a consequence of):		
b.	Coronary Artery Disease	> 5-10years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c.	Smoking	> 10years
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, smoking, Dementia, B12 deficiency

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N. Punjabi

29c. License number: D46132

29d. Date signed (Month, Day, Year): 1/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. Punjabi Church Hospital.

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-0099-510
B.K.S ITEMS· 27, 28d, PER MEO
FILM g-743 1/30/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OLIVE Weckerly SINK
2. Data of Death (Month, Day, Year): JAN. 6, 1997
3. Time of Death: 1225 AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL S.T.U
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 314-22-3621
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 26, 1906
9. Birthplace (State or Foreign Country): OHIO

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2211 W. Rogers Ave.
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Linotype Operator
16b. Kind of Business/Industry: Newspaper
17. Father's Name (First, Middle, Last): Frank Adolph Weckerly
18. Mother's Name (First, Middle, Maiden Surname): Margaret Peyton
19a. Informant's Name/Relationship (Type, Print): Edwin W. McGuire Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5203 Sturgeon Creek Pky. Midland, Michigan 48640
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns.
Date: 1/11/97
20c. Location - City or Town, State: Timonium, Maryland
21. Signature of Funeral Service Licensee: Robert M. Kratz
22. Name and Address of Facility: Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple Injuries

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient ☒☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident ~~3☐ Suicide~~ 4☐ Homicide 5☐ Pending investigation 6☒☒ Could not be determined

28a. Date of Injury (Month, Day, Year): 1-5-97

28b. Time of Injury: UNK M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject jumped from building

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2211 W. Rogers Ave 21209

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jaron Locke MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JAN. 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA M. SHRIVER
2. Date of Death Month Day Year: JAN. 6. 1997
3. Time of Death: 9:00 PM.
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-32-6380
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 31, 1906
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 31 Clipper Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4yrs
16a. Dacadant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Andrew Schmidt
18. Mother's Name (First, Middle, Maiden Surname): Rose

19a. Informant's Neme/Relationship (Type, Print): Estelle Kluver/neice
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 Red Bud Road Edgewood Md. 21040

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc. Date: 1/8/97
20c. Location - City or Town, State: Balitmore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Hom e of Essex' 300 Mace Ave. Balitmore MD. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediata Cause (Final disease or condition resulting in daath)
e. SEPSIS

Dua to (or as a consequanca of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Dua fo (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ARTERIOSCLEROSIS.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A.R. Nazemino
29c. License number: D 17322
29d. Date signed (Month, Day, Year): JAN. 6. 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.P. NAZEMI. M.D CHURCH HOSPITAL BALT.

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00235

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Cecelia Schwandtner
2. Data of Death — Month: Jan. Day: 4, Year: 1997
3. Time of Death: 7:48AM
4a. Facility Name (If not Institution, give street and number): 3117 Hunt Rd.
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-14-8376
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 10, 1921
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3117 Hunt Road
10f. Zip Code: 21047
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th. — College (1-4or 5+): n/a/
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John Maenner
18. Mother's Name (First, Middle, Maiden Surname): Nettie Brockmeyer

19a. Informant's Name/Relationship (Type, Print): Edward J. Schwandtner, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3117 Hunt Road Fallston, Md. 21047

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Mausoleum
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Grds. Date: Jan. 7, 1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: E. F. Lassahn Funeral Home
22. Name and Address of Facility: E. F. Lassahn Funeral Home, 11750 Belair Road Kingsville, Md. 21087

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmony Disease — 10 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [illegible], DO FACP
29c. License number: H34022
29d. Date signed (Month, Day, Year): January 6 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Lacosti, DO 1308 Business Center Way Edgewood MD

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK J. SWINN

2. Date of Death Month: JAN Day: 6 Year: 97

3. Time of Death: 7.18 am

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard Co.

Funeral Director

5. Social Security Number: 216-96-5499

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 28 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 05, 1968

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Glyndon

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4412 Worthington Ave.

10f. Zip Code: 21071

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 02

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Contractor

16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): Eric Dennis Swinn

18. Mother's Name (First, Middle, Maiden Surname): Sylvia French

19a. Informant's Name/Relationship (Type, Print): Carole (nee Ulrich) Swinn (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4412 Worthington Ave. Glyndon, Maryland 21071

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 01/10/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic testicular Cancer — 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Brain metastasis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] M.D.

29c. License number: D 41139

29d. Date signed (Month, Day, Year): JAN 6, 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Howard County Gen. Hospital Columbia, Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Judith Davidson-Ramsell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carroll William Steele, Sr.

2. Date of Death (Month, Day, Year): January 5, 1997

3. Time of Death: 2:40 P.M.

4a. Facility Name (If not institution, give street and number): Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-12-0860

6. Sex: [X] 1 M [ ] 2 F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 19, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: [X] 1 Yes [ ] 2 No

10e. Street and Number: 4122 Hamilton Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [ ] 1 Yes [X] 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Route Salesman

16b. Kind of Business/Industry: Bakery

17. Father's Name (First, Middle, Last): Hezekia Nicholas Steele, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Minnie Rae Lambert

19a. Informant's Name/Relationship (Type, Print): Fredericka Hazel Steele/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4122 Hamilton Avenue, Baltimore, Maryland 21206

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery

Date: 1/9/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: William M. Boyd

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Adult Respiratory Distress Syndrome — one week

Due to (or as a consequence of):
b. Pneumonia — twelve days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [ ] 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [X] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death (Check only one): Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA | Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other (Specify)

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Abenaa Brewster MD

29c. License number: N2474

29d. Date signed (Month, Day, Year): January, 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abenaa Brewster Johns Hopkins Hospital, Bayview

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne McLean Steigelman

2. Date of Death (Month, Day, Year): Jan. 7, 1997

3. Time of Death: 7:50 AM

4a. Facility Name (If not institution, give street and number): Cherrywood Manor Healthcare Center

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-38-3639

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 25, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 217 Mystic Wood Rd.

10f. Zip Code: 21136

10g. Citizen of What Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telemarketer

16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): John M. Steigelman

18. Mother's Name (First, Middle, Maiden Surname): Mary M. Wilson

19a. Informant's Name/Relationship (Type, Print): George W. Steigelman / brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 Mystic Wood Rd. Reisterstown, Md. 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Thomas Cem. | Date: 1-9-97

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Servica Licensee: C. Brian Powell

22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Road, Reisterstown, Md. 21136

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in daeth)
e. Non Hodgkins Lymphoma — 2½ years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part it. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Homa 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ira H. Copeland M.D.

29c. License number: D27034

29d. Dete signed (Month, Day, Year): January 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira H. Copeland, M.D. 5310 Old Court Rd. Randallstown, Md. 21133

8

State Registrar

31. Dete filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Scott

2. Date of Death: Month Jan. Day 6, Year 1997

3. Time of Death: 12:43 AM

4a. Facility Name (If not institution, give street and number): Ravenwood Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 223-01-9742

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): March 3, 1902

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2102 N. Fulton Ave.

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Negro

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): Martha Young

19a. Informant's Name/Relationship (Type, Print): Mrs. Doris Drake (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4533 Manorview Rd. Balto. Md. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 1/9/97

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASCVD	>10 YRS.
Due to (or as a consequence of): b.	Senile dementia	>5 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	sacral decubitus.	1 year
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Rama Shankar

29c. License number: D48046

29d. Date signed (Month, Day, Year): 1-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rama Shankar 821 N. Eutaw St Ste 308

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item: 31, per V.R. G-743 1/8/97 reb

Reg. No. 97 00240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marlyn Rider Schleupner

2. Data of Death Month Day Year: Jan. 3 1997

3. Time of Death: 7:38 am

4a. Facility Name (If not institution, give street and number): 6 Helena Ave.

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-30-4368

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug/ 5,1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedant

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 6 Helena Ave.

10f. Zip Coda: 21221

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast greda completed)

Elamentary/Secondary (0-12): 8th

Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Housewife

16b. Kind of Businass/Industry: own home

17. Fathar's Nama (First, Middla, Last): Elmer Buxenstein Sr.

18. Mothar's Nama (First, Middla, Maiden Surnama): Helena Bertha Hammer

19a. Informant's Neme/Ralationship (Type, Print): Janice Ratliff/daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 6 Helena Ave. Balitmore Md. 21221

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Baltimore National Cemetery

Data: 1/6/97

20c. Location - City or Town, Stata: Balitmore Md.

21. Signatura of Funaral Sarvice Licensaa: R. Terry Connelly

22. Nama and Address of Facility: Connelly Funeral HOme of Essex 300 MAce AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line.

		Approximata Interval Between Onsat and Death
Immediata Causa (Finel disaasa or condition resulting in daath) a.	Lung cancer	3 yrs.
Due to (or as a consequence of): b.	Post Obstructive pneumonia	3 week
Sequantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last Due to (or as a consequence of): c.	Diabetis Mellitus	10 yrs
Due to (or as a consequence of): d.		

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings availabla prior to compiation of causa of daath? 1☐ Yas 2☐ No

25. Was cese referred to medicel exeminar? 1☐ Yes 2☒ No

26. Place of Death (Check only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA

Othar: 4☐ Nursing Homa 5☒ Residence 8☐ Othar (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 8☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurred at the time, data end place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to tha ceuse(s) and mannar stated.

29b. Signature and title of certifier: A. Wychulis

29c. Licansa number: D41680

29d. Data signed (Month, Day, Year): 1-3-97

30. Nama and address of person who completed ceuse of daath (Item 23e) (Type, Print): Adolph Wychulis 406 Eastern Blvd - Balto, MD 21221

State Registrar

31. Dete filad (Month, Day, Year): 1-397

32. Registrar's Signature: JAN 0 8 1997 Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Szaleski

2. Date of Death Month Day Yaer: January 04 97

3. Tima of Death: 3:37 Pm

4a. Facility Neme (If not institution, give street end number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Numbar: 213 32 8363

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. lest birthday): 59 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): May 14, 1937

9. Birthplece (Steta or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 690 Powhatten Beach Rd.

10f. Zip Code: 21122

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Yeer or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - Americen Indian, Black, White, etc. Specify: White

15. Decedant's Educetion (Specify only highest grade complated)

Elamantary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool and Die Maker

16b. Kind of Business/Industry: Metal Manufacturing

17. Father's Name (First, Middle, Lest): Stephen Szaleski

18. Mother's Name (First, Middle, Maiden Surneme): Lorraine Preston

19a. Informant's Name/Relationship (Typa, Print): Pamela D. Szaleski / wife

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 690 Powhatten Beach Rd., Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetary, cremetory or other piece): Green Mount Crematory

Data: 1/8/97

20c. Location - City or Town, State: Baltimore, MD

21. Signatura of Funeral Service Licensee: Stephen D. Lohrmann

22. Nama end Addrass of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications thet ceusad the deeth. Do not anter the mode of dying, such es cerdiac or respiratory errest, shock, or haart failure. List only ona cause on each line.

Approximate Interval Between Onsat end Death

Immediata Causa (Final disaase or condition resulting in daath)

a. Emphysema — Due to (or as a consequence of):

10 years

Saquentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated avants resulting in deeth) Last

b. — Due to (or as a consequence of):

c. — Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Wara autopsy findings available prior to completion of causa of daath? 1 [ ] Yes 2 [✓] No

25. Was cese referred to medical exeminer? 1 [ ] Yas 2 [✓] No

26. Piece of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpetient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Deeth: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datermined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [✓] **Certifying Physician**: To tha best of my knowledge, death occurred at the tima, deta and place, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to tha ceusa(s) and mannar stated.

29b. Signatura and filla of certifier: Elliott Lloyd MD

29c. Licensa number: D20094 - Maryland

29d. Data signed (Month, Day, Year): 01/07/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): 7845 Oakwood Rd. Glen Burnie, md. 21061

State Registrar

31. Dete filed (Month, Day, Yaar): JAN 08 1997

32. Registrar's Signature: Julia Davidson-Rondelle

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

97 00242

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES SETTLE					2. DATE OF DEATH (Month, Day, Year): JAN 2 97		3. TIME OF DEATH: 4:30 P M
4. SOCIAL SECURITY NUMBER: 241-42-4787	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JUL. 13, 1928		8. BIRTHPLACE (State or Foreign Country): N. CAROLINA
9a. FACILITY NAME (If not institution, give street and number): 4800 SETON DRIVE					9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: n/a
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY: n/a				10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? XX 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4800 SETON DRIVE					10f. ZIP CODE:		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XX	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES XX				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XX Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+): -					16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PORTER		16b. KIND OF BUSINESS/INDUSTRY: VARIOUS
17. FATHER'S NAME (First, Middle, Last): THOMAS SETTLE					18. MOTHER'S NAME (First, Middle, Maiden Surname): CLEONIE MC COLLUM		
19a. INFORMANT'S NAME (Type/Print): ANTONETTE HARRISON					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2444 BRENTWOOD AVE., BALTIMORE, MD #18		
20a. METHOD OF DISPOSITION: X1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): VOSHELL MEMORIAL GARDENS DATE 1-7-97		20c. LOCATION — City or Town, State: DUNDALK, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]					22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH FH.-1101 E. NORTH AVE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GASTRIC CARCINOMA	2/96
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Tasneem Lakhani

29c. LICENSE NUMBER: D28595

29d. DATE SIGNED (Month, Day, Year): ▶ 1/2/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

31. DATE FILED (Month, Day, Year): JAN 0 8 1997

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WRC
97-0064-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27 per MEO G-744 2/19/97 *Certificate of Death*

Reg. No. 97 00243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GARY STEVENSON III
2. Date of Death (Month, Day, Year): JAN. 04, 1997
3. Time of Death: 4:36 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-49-1322
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months 1, Days 30 | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 11-05-96
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4216 Loch Raven Blvd. Apt. #442
10f. Zip Code: 21218
10g. Citizen of What Country: USA
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Child; College (1-4 or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Child
16b. Kind of Business/Industry: Child
17. Father's Name (First, Middle, Last): Gary Stevenson Jr.
18. Mother's Name (First, Middle, Maiden Surname): Rosslind Harrell
19a. Informant's Name/Relationship (Type, Print): Rosslind Harrell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4216 Loch Raven Blvd. Apt. #442 Baltimore Md. 21218
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 01-09-97
20c. Location - City or Town, State: Lansdowne, Md.
21. Signature of Funeral Service Licensee: Valerie M Davis
22. Name and Address of Facility: Baltimore, Md. 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SUDDEN INFANT DEATH SYNDROME	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☑ ~~Pending~~ investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Ross Hall
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JAN. 05, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN A. KOROL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: Sylvia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00244

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen K SIEGEL

2. Date of Death Month: 1 Day: 5 Year: 97

3. Time of Death: 455am

4e. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 102-01-8025

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 28,1908

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1131 UNIVERSITY BOULEVARD W

10f. Zip Code: 20902

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): Ø

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BOOKKEEPER

16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name *(First, Middle, Last)*: ISRAEL SIEGEL

18. Mother's Name *(First, Middle, Maiden Surname)*: REBECCA GROSS

19a. Informant's Name/Relationship *(Type, Print)*: REVELLA EBER/NIECE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 GULF ROAD, EAST BRUNSWICK, NJ 08816

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOUNT ZION CEMETERY

Date: 1/7

20c. Location - City or Town, State: MASPETH, NEW YORK

21. Signature of Funeral Service Licensee: Janice Fleck

22. Name and Address of Facility: FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finat disease or condition resulting in death) a.	CARDIOGENIC SHOCK	1 HR
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last b.	EXPANDING ABDOMINAL AORTIC ANEURYSM	18 HRS
Due to (or as a consequenca of):		
c.	ABDOMINAL AORTIC ANEURYSM	4 YEARS
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: HEMORRHAGE

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evsiiable prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harry D [illegible] MD

29c. License number: D 21153

29d. Dete signed *(Month, Day, Year)*: 1-5-97

30. Name and address of person who completed ceuae of death (item 23a) (Type, Print): GARRY D. RUCK, 11120 New Hampshire Ave #201, SILVER SPRING MARYLAND

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrar's Signature: Linda Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE INDIANA SWANN
2. Date of Death (Month, Day, Year): January 03, 1997
3. Time of Death: 8:13p.m.
4a. Facility Name (If not institution, give street and number): St. Marys Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 212-62-1775
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.30, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 22680 Cedar Lane Court Apt. #2311
10f. Zip Code: 20650
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: homemaker

17. Father's Name (First, Middle, Last): William Preston Higgs
18. Mother's Name (First, Middle, Maiden Surname): Jenny Maude Higgs Burroughs

19a. Informant's Name/Relationship (Type, Print): grandson Samuel Francis Swann, III
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 326, Newburg, Maryland 20664

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. # Septic Shock — Days

Due to (or as a consequence of): Bilateral Pneumonia — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Walter Valenteen MD
29c. License number: D50163
29d. Date signed (Month, Day, Year): 1/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Walter Valenteen St Marys Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00246

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RHODA SHEETS

2. Date of Death: Month JANUARY Day 2 Year 1997

3. Time of Death: 9:35 PM

4a. Facility Name (If not institution, give street and number): Berlin Nursing Rehabilitation Center

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 233-48-8070

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 3, 1905

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9715 Healthway Drive

10f. Zip Code: 21811

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: homemaker

17. Father's Name (First, Middle, Last): John Johnson

18. Mother's Name (First, Middle, Maiden Surname): Rosa Johnson

19a. Informant's Name/Relationship (Type, Print): Sibyl Scott/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5865 Richardson Road, Cambridge, MD 21613

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary artery disease — yrs

Due to (or as a consequence of):

c. Diffuse atherosclerosis — yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF - Renal Fx

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D02026

29d. Date signed (Month, Day, Year): 1-3-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FEDERICO G. ARTHES, MD 1622A OCEAN PINES BERLIN MD 21811 410-641-4400

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Linda Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Peter Saputo
2. Date of Death Month Day Year: Jan 04 1997
3. Time of Death: 2241
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 326-30-2207
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 24, 37
9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 300 Byrn Street
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef
16b. Kind of Business/Industry: Resturant

17. Father's Name (First, Middle, Last): John Saputo
18. Mother's Name (First, Middle, Maiden Surname): Rose Marie Capriata

19a. Informant's Name/Relationship (Type, Print): unknown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 West Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. AIDS

Due to (or as a consequence of):
b. Ca. Prostate with Metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Spinal Stenosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Shirin Mohammad
29c. License number: D0050799
29d. Date signed (Month, Day, Year): January 04, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shirin Mohammad

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ITEMS: 16a,16b, PER F.H. **Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

FILM G-743 1/24/97 t.t
FilmG743 item 19b per FH 1-8-97 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00248

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Thompson

2. Date of Death Month / Day / Year: January 1, 1997

3. Time of Death: 2:40 pm

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 248-38-8698

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APR. 22, 1928

9. Birthplace *(State or Foreign Country)*: CHESTER, SC

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6603 WYCOMBE WAY

10f. Zip Code: 21234

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 th; College (1-4 or 5+): -

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ~~BUS~~ ~~COMPANY~~ FOREMAN

16b. Kind of Business/Industry: PBR RAILROAD COMPANY ~~SCHOOL~~ ~~SYSTEM~~

17. Father's Name *(First, Middle, Last)*: GEORGE THOMPSON

18. Mother's Name *(First, Middle, Maiden Surname)*: JANNIE YOUNG

19a. Informant's Name/Relationship *(Type, Print)*: YVONNE STENHOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1832 ASHLAND AVENUE, BALTIMORE, MD 21205 #34

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BALTIMORE NATIONAL CEM.

Date: 1-9-97

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Marlin E. Funeral

22. Name and Address of Facility: WM. C. MARCH FH.-1101 E. NORTH AVE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 20 min

Immediate Cause (Final disease or condition resulting in death)
e. Cardiac arrest of undetermined cause

Due to (or as a consequence of):
b. may be from the multiple underlying medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. causes listed in part II of 23a.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
cavitary pneumonia
ulcerative colitis
fungal esophagitis, gastric ulcer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Song, M.D.

29c. License number: 96014

29d. Date signed *(Month, Day, Year)*: January 1, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lijun Song, JHBMC 4940 Eastern Ave. Baltimore, MD 21224.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The information is that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] should be detached for use as the burial-transit

9
10+1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARRY W. TAYLOR
2. Date of Death (Month, Day, Year): JANUARY 5, 1997
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): 722 LINNARD STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-74-2752
6. Sex: XX 1☐ M 2☐ F
7. Age (In yrs. last birthday): 34 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3 12 1962
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. inside City Limits: XX 1☒ Yes 2☐ No
10e. Street and Number: 722 LINNARD STREET
10f. Zip Code: 21229
10g. Citizen of What Country? US

11. Marital Status: 1XX Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: XX
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STOCK CLERK
16b. Kind of Business/Industry: BUILDING

17. Father's Name (First, Middle, Last): WAVERLY TAYLOR
18. Mother's Name (First, Middle, Maiden Surname): KATHERINE CALDWELL

19a. Informant's Name/Relationship (Type, Print): KATHERINE JAMES (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 722 LINNARD ST. BALTIMORE, MARYLAND 21229

20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEM. PK.
Date: 1/9/97
20c. Location - City or Town, State: BALTIO,,MD.

21. Signature of Funeral Service Licensee: Olenda Hecht CFSP #281
22. Name and Address of Facility: PHILLIPS FUNERAL HOME 1721 N. MONROE ST. BALTIO.,MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)
a. RENAL FAILURE — 6 MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b. ACQUIRED IMMUNE DEFICIENCY SYNDROME — 2 YEARS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
ANEMIA

23b. Did tobacco uss contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, snd due to the cause(s) and manner stated.

29b. Signature end title of cartifier: Jonathan M Zenilman M.D.
29c. License number: D39358
29d. Date signed (Month, Dey, Year): JANUARY 8 1997

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN M ZENILMAN MD JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21205

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FilmG743 item 10b per FH 1-8-97 rja

Certificate of Death

Reg. No. 97 00250

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARBARA ANN TEIXEIRA
2. Date of Death Month Day Year: JANUARY 2,997
3. Time of Death: 1:30 am
4a. Facility Name (If not institution, give street and number): 935 ARGYLE AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 091-56-4224
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 1, 1954
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ XX Yes 2☐ No
10e. Street and Number: 935 ARGYLE AVENUE
10f. Zip Code: 21201
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed XX Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No XX Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4or 5+): 1year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: VARIOUS TRADES

17. Father's Name (First, Middle, Last): JOHN GILBERT HOLLAND
18. Mother's Name (First, Middle, Maiden Surname): LUCILLE WILLIAMS

19a. Informant's Name/Relationship (Type, Print): TASHA TEIXEIRA
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 935 ARGYLE AVENUE , BALTIMORE, MD

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ~~GRRENMOUNT~~ Greenmount CREMATORY
Date: 1-8-97
20c. Location - City or Town, Stete: BALTIMORE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Feciliity: WM. C. MARCH FH.-1101 E. NORTH AVENUE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finai disease or condition resulting In death): e. AIDS End stage.

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given In Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compietion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and menner es stated. 2☐ **Medical Exeminer**: On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Dr. Reddick Lane
29c. License number: H48247
29d. Date signed (Month, Day, Year): Jan. 6, 1997

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): C. Reddick Lane 1017 E. Baltimore St 21202

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

State Registrar

31. Date filed (Month, Dey, Year): ~~11-67~~ JAN 0 8 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

WRC
97-0088-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00251

Physician /Medical Examiner

1. Decadant's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
AUDREY GERTRUDE TILLIS	JAN. 05, 1997	4:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2300 Searles rd.	DUNDALK	Balto. Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-36-1480	1☐ M 2☒ F	65 Yrs.			June 26, 1931	Maryland

To Be Completed by Funeral Director

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
2300 Searles Road	21222	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Dacedent's Educetion (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
9 Years		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Surnama)
Oscar L. Moon	Ruth Stockman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Husband Mr. James O. Tillis, Sr.	2300 Searles Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)	Oak Lawn Cemetery	01/08/1997	Baltimore, Maryland

21. Signatura of Funeral Service Licensea	22. Name and Address of Facility
▶ Johnny L Duda	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONTACT GUNSHOT WOUND OF HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

Depression

23b. Did tobecco ues contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
HOPDONY 1☒ Yes 2☐ No	1☐ Yes 2☐ No

25. Was cese raferred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined	1-5-97	1400 M	1☐ Yas 2☒ No	SUICIDE SHOT SELF

28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2300 SEARLES RD BALTIMORE CO MD

29a. Certifiar (Check only one) 1☐ **Certifying Phyeician:** To tha best of my knowledge, daath occurrad at the time, data and place, and dua to the causa(s) and manner as stated.
2☒ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the ceuse(s) and manner stated.

29b. Signatura and title of certifiar	29c. License number	29d. Date signad (Month, Day, Year)
▶ Marysia A. Kozol MD	O.C.M.E.	JAN. 06, 1997

30. Name and address of parson who completed causa of daath (Item 23a) (Type, Print)
MARYSIA A. KOZOL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
JAN 08 1997	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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97-0101-510

CMK ITEMS: 23 PART I, 27, 28a-f,
PER MEO FILM g-743 1/27/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
EDWIN	J	THOME	JANUARY 05, 1997	1958PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3707 PARK SIDE DRIVE	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-42-6732	1☒ M 2☐ F	53 Yrs.			Feb. 28 1943	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3707 Parkside Dr.	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+4	Unemployed	N/A

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Malden Surname)		
Edwin	J.	Thome,Sr.	Margaret	Dolores	Kozma

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Thome/Mother	28 Allegheney Ave #1601 Towson,Md. 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment	Lorraine Park Maus.	1-9-97	Woodlawn,Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Ruck Towson Funeral Home,Inc. 1050 York Rd. Towson,Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY SMOKE INHALATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined	1-5-97	7:44 P M	1☐ Yes 2☒ No	VICTIM OF HOUSE FIRE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
RESIDENCE	3707 PARK SIDE DRIVE BALTIMORE, MARYLAND

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	JANUARY 06, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARY SIOS A. KOPSE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 08 1997	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL JOSEPH TOMASKI

2. Date of Death — Month: JANUARY Day: 02 Year: 1997

3. Time of Death: 09:24 A.M. FOUND

4a. Facility Name (If not institution, give street and number): 200 FT. MEADE ROAD

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 077-40-8422

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): FEB. 15, 1948

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGE

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 200 FT. MEADE ROAD #701

10f. Zip Code: 20707

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MASTER LIBRARIAN

16b. Kind of Business/Industry: EMPLOYMENT CONTRACTOR

17. Father's Name (First, Middle, Last): ANTHONY JOHN TOMASZEWSKI

18. Mother's Name (First, Middle, Maiden Surname): MILDRED B. KIELY

19a. Informant's Name/Relationship (Type, Print): MILDRED B. TOMASKI/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2353 SHELLEY STREET, #11, CLEARWATER, FL 34625

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE-WASHINGTON CR.

Date: 1/5/97

20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CHRONIC ASTHMA & DIABETES MELLITUS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: DEPUTY MEDICAL EXAMINER D 33954

29d. Date signed (Month, Day, Year): JANUARY 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIA JR. M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUGENE H. THOMAS SR
2. Date of Death: Month January Day 3 Year 1997
3. Time of Death: 230 P.M.
4a. Facility Name (If not institution, give street and number): VAMC
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-18-2793
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 28, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decadant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 41 Nerbay Road
10f. Zip Code: 21221
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): Eugene Henry Thomas, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Amelia Darchicourt

19a. Informant's Name/Relationship (Type, Print): Joseph L. Thomas Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8428 Kavanagh Road Baltimore, Maryland 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 1/6/1997
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Johnny L. Gibbs
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACIDOSIS	minutes
Due to (or as a consequence of):		
b.	PNEUMONIA	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	LUNG CANCER	months
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D8628
29d. Date signed (Month, Day, Year): January 3 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Szmudzyn 10 North Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne Catherine Wilcox

2. Date of Death: Month 1 Day 6 Year 97

3. Time of Death: 12:30 pm

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 220-24-1219

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): April 3, 1914

9. Birthplece (Stete or Foreign Country): PA.

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Steta: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1601 E. Belvedere Avenue

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12 yrs.

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary-Taxation & Assesments State of Maryland

16b. Kind of Business/Industry

17. Fathar's Neme (First, Middle, Last): Frederick Baltimore

18. Mother's Neme (First, Middle, Meiden Surname): Susan Gaydosik

19a. Informent's Neme/Reletionship (Type, Print): Mrs. Mary T. Buckmaster

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 1801 C Sherwood Avenue Baltimore, Md. 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or othar place): Gardens of Faith Cem. Jan.

Dete: 9-1997

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funarel Service Licensee: Lassahn Funeral Home

22. Neme and Address of Feciility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or conditlon resulting in deeth)

e. Suspected myocardial infarction — few hours

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete causa. Entar Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b. HTBP — ~20 yrs.

Due to (or as e consequence of):

c. DM — >15 yrs

Due to (or es a consequance of):

d. smoking history

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yas 2☐ No

26. Place of Death (Check only one) Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA Other: 4☑ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: Gail D. Miller, MD

29c. License number: D22719

29d. Dete signed (Month, Day, Year): 1/6/97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): GAIL W. MILLER, 9506 Harford Rd. Balto. Md. 21234

State Registrar

31. Date filed (Month, Dey, Year): JAN 08 1997

32. Registrer's Signeture: Julia Davidson-Ramsey

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00256

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Fullum Ward

2. Date of Death Month: JAN Day: 06 Year: 97

3. Time of Death: 3:25 PM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220-46-3076

6. Sex: 1☐ M 2☒ F XX

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 4, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 717 Maiden Choice Ln. Apt. 314

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): | College (1-4or 5+): 4 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: William Fullum

18. Mother's Name *(First, Middle, Meiden Surname)*: Katherine Kogler

19a. Informant's Name/Relationship *(Type, Print)*: Phoebe Sachs Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25 Mills Ridge Rd. Lewis, Delaware 19958

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Druid Ridge Cemt. Date: 1/9/97

20c. Location - City or Town, Stete: Pikesville, Md.

21. Signature of Funeral Service Licensee: Robert M. Kratz

22. Name and Address of Facility: Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	Cerebro Vascular Accident.	>4 yr.
Due to (or as a consequence of): b.	Hypertension	>4 yr.
Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last — Due to (or es a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*:

28b. Time of Injury:

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner as steted. 2☐ **Medical Examinar:** On the besis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: DR NARRETT Thampan

29c. License number: D0057088

29d. Dete signed *(Month, Day, Year)*: JAN 06 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thaw Poon, St Agnes Hospital, 900 Caton Ave, Baltimore, MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1997

32. Registrar's Signeture: Gloria Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elaine Geraldine Wayman

2. Date of Death (Month, Day, Year): Jan. 3, 1997

3. Time of Death: 1:46 A.M.

4a. Facility Name (If not institution, give street and number): 1507 Copeland Rd.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-32-6605

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 19, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1507 Copeland Rd

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired): Claims Manager

16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): George Anderson Waddell

18. Mother's Name (First, Middle, Maiden Surname): Elaine Geraldine Young

19a. Informant's Name/Relationship (Type, Print): Mr. Wilbur Wayman (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1507 Copeland Rd. Balto. Md. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn

Date: 1/9/97

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil S. Friedman

29c. Licensa number: 042178

29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil S. Friedman 4000 Old Court Rd. Ste. 306 Balto, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vernon Henry Wilson

2. Date of Death — Month: Jan. Day: 6 Year: 1997

3. Time of Death: 5:21 P.M.

4a. Facility Name (If not institution, give street and number): Bowie Health Care Center

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218 14 1144

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 9, 1912

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 5810 Park Drive

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondery (0-12): 3 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Own Business

17. Father's Neme (First, Middle, Last): William Henry Wilson Sr.

18. Mother's Nama (First, Middle, Meiden Surname): Willie Effie Rutledge

19a. Informant's Name/Reletionship (Type, Print): William Wilson Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5810 Park Drive Bowie Maryland 20715

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Mt. Oak Cemetery — Date: 1/10/97

20c. Location - City or Town, State: Mitchellville Md.

21. Signature of Funeral Servica Licensee: Robert E. Evans, Pres

22. Name and Address of Facility: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23e. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finai disease or condition resulting in death) a.	Atherosclerotic heart disiare.	10 yeen +
Due to (or as a consequence of): b.	Hx of Dysthmic type Atrial Fibrillation	6 months.
Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury thet initiated events resulting in daath) Last — Due to (or as a consequanca of): c.	NIDDM	5 + years.
Due to (or as a consequanca of): d.	Prostate carcinoma -	3 years.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

Hypertension

S/p. Upper GI bleeding 2° to duodenal ulcer 10/1996-

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and placa, and due to tha cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated.

29b. Signature and titia of certifier: Alain G. Champaloux MD

29c. License number: D42049 MD.

29d. Date signed (Month, Dey, Year): 1/7/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alain. G. CHAMPALOUX MD. Upper Marlboro MD. 20772

State Registrar

31. Dete filed (Month, Day, Year): JAN 08 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00259

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY WITZEL

2. Date of Death Month: JANUARY Day: 06 Year: 1997

3. Time of Death: 07.55 PM

4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-42-2245

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8/7/10

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3207 Westfield Avenue

10f. Zip Code: 21214-1444

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: homemaker

17. Father's Name *(First, Middle, Last)*: Clarence Augustus Tucker

18. Mother's Name *(First, Middle, Maiden Surname)*: Eliza Ann Tucker Sadler

19a. Informant's Name/Relationship *(Type, Print)*: Nancy L. Witzel/daughter-in-law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3207 Westfield Ave., Baltimore, MD 21214-1444

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 5 DAYS

Due to (or as a consequence of):

b. PNEUMONIA — 5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joginder P Mehta MD

29c. License number: 041410

29d. Date signed *(Month, Day, Year)*: January 06, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1997

32. Registrar Signature: ▶

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00260

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): GEORGIA ARVIN
2. Deta of Deeth — Month: JANUARY Day: 6 Year: 1997
3. Time of Death: 0600 AM
4a. Facility Name (If not Institution, giva street and number): SUBACUTE UNIT AT NORTHWEST
4b. City, Town, or Location of Deeth: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-26-0056
8. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Yaar — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Dele of Birth (Month, Dey, Year): June 8, 1909
9. Birthplace (State or Foreign Country): GEORGIA

Usuel Residence of Decedant

10a. Slala: MARYland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 3729 MARMON Avenue
10f. Zip Code: 21207
10g. Citizan of What Country?: U.S.A.

11. Marital Slatus: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yaar or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERICAL
16b. Kind of Business/Industry: WOMANPOWER

17. Father's Neme (First, Middle, Last): John H. Johnson
18. Mother's Name (First, Middle, Maiden Surname): SARAH MANNERY

19a. Informant's Name/Relationship (Type, Print): Yvonne Shephard
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 346 Washington Ave RANDALLstown Md 21244

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): ARbutus Mem. Pk. Date: 1/09/97
20c. Location - City or Town, State: ARbutus, Md
21. Signature of Funeral Service Licensee: Donna Adams Jones
22. Name and Address of Facility: MARSHALL W. Jones JR. Funeral Home, PA 101 Edmondson Ave. Balto Md 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION

Due to (or es a consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest:
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert t.

23b. Did tobacco use contribute to the causes of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Ware autopsy findings availeble prior to completion of causa of death? 1☐ Yas 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yas 2☑ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpeliani 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Othar (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at the time, dale and piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: C. Ravi MD
29c. License number: D37333
29d. Dala signed (Month, Day, Year): JANUARY 6, 1997

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): C-RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Dete filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signeture: Linda Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NATHAN ABRAMOVITZ
2. Date of Death Month Day Year: JANUARY 8, 1997
3. Time of Death: 4:10 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-05-1829
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 5, 1909
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 3447 CARRIAGE HILL CIR., APT. T-2
10f. Zip Code: 21133
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GARBAGE MAN
16b. Kind of Business/Industry: BALTO. CITY DEPT. OF SANITATION
17. Father's Name (First, Middle, Last): HENRY ABRAMOVITZ
18. Mother's Name (First, Middle, Maiden Surname): GOLDIE GLICKMAN
19a. Interment's Name/Relationship (Type, Print): IVA BELLE ABRAMOVITZ (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3447 CARRIAGE HILL CIR, APT. T-2 RANDALLSTOWN, MD 21133
20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ANSHE NEISEN | Date: 1/8/97
20c. Location - City or Town, State: ROSEDALE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. LUNG CARCINOMA	UNDETERMINED
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: UPPER GASTROINTESTINAL BLEEDING; THORACOABDOMINAL ANEURYSM; CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ✓ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ✓ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ✓ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ✓ No

26. Place of Death (Check only one): Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D19502
29d. Date signed (Month, Day, Year): JANUARY 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ORLANDO B. CONANAN MD NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: [signature] Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

WRC
97-0034-510

Item17 1-13-97 FilmG743 W.H.per Doctor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FilmG743 item 4 Per ME 108097 rja

Certificate of Death

Reg. No. 97 00262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES Arthur BOYD
2. Date of Death (Month, Day, Year): JAN. 02, 1997
3. Time of Death: 6:34 PM
4a. Facility Name (If not institution, give street and number): 1006 ~~STEMFORD AVE.~~ Stamford Road
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 251-30-6875
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 5, 1930
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 1006 Stamford Road
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Legion Construction Co.

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Neme (First, Middle, Maiden Surneme): Effie

19a. Informant's Name/Relationship (Type, Print): wife — Eleanor L. Boyd
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1006 Stamford Road Baltimore, Maryland 21229

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Western Star Cemetery
Date: Jan 7th
20c. Location - City or Town, State: Baltimore County, MD

21. Signature of Funeral Service Licensee: Ernest R. Tenyt
22. Name end Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, Maryland 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? inspected 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end manner as steted. 2 X **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JAN. 05, 1997

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 0 8 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00263

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Diane Brooks

2. Data of Death — Month: 1 Day: 6 Year: 97

3. Time of Death: 650 PM

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bay View

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 275-46-8172

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: May 1, 1944

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5101 Herring Rund Drive

10f. Zip Code: 21214

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 3 years

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary - Education Assit.

16b. Kind of Business/Industry: Baltimore City Schools

17. Father's Name *(First, Middle, Last)*: Maxwell Brooks

18. Mother's Name *(First, Middle, Maiden Surname)*: Sara Naomi Gaskin

19a. Informant's Name/Relationship *(Type, Print)*: Sara Naomi Brooks mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5101 Herring Run Drive Baltimore, Maryland 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Arbutus Memorial Park

Date: Jan 11

20c. Location - City or Town, State: Baltimore County, MD

21. Signature of Funeral Service Licensee: Gary L Pollen

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer Metastatic — 16 Mos

Due to (or as a consequence of):

b. S/P Mastectomy 2/96 — 11 Mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

Glaucoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: WBG

29c. License number: D04383

29d. Date signed *(Month, Day, Year)*: 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. B. Greenough MD 5505 Hopkins Bayview Circle Balt. MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Print. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00264

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH COHEN

2. Data of Death — Month: JANUARY Day: 5 Yaar: 1997

3. Time of Death: 4:12 AM

4a. Facility Nama *(If not institution, giva street and number)*: NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-03-5201

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Yaar — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Yaar)*: MAR. 4, 1907

9. Birthplaca *(State or Foraign Country)*: MARYLAND

Usual Rasidance of Decedant

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 130 SLADE AVE., APT. 322

10f. Zip Coda: 21208

10g. Citizan of What Country?: USA

11. Maritai Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decadant's Education *(Specify only highast grada compiatad)*: Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Fathar's Name *(First, Middla, Last)*: LEON LIEBERMAN

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: ANN KAPLAN

19a. Informant's Name/Relationship *(Type, Print)*: MR. MAURICE FRIED(SON-IN-LAW)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 1 HIGHSTEPPER CT., APT. 302 BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar placa)*: (ANSHE EMUNAH)AITZ CHAIM Data: 1-6-1997

20c. Location - City or Town, Stata: BALTIMORE, MD

21. Signatura of Funaral Sarvica Licansaa: Michael Krieger

22. Nama and Address of Facility: SOL LEVINSON & BROS.,INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or compiications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. SEPSIS

Dua to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiatad avants rasulting in death) Last

b. SMALL BOWEL INFARCTION

Due to (or as a consequance of):

c. GASTRO INTESTINAL BLEED

Dua to (or as a consequanca of):

d. MYOCARDIAL INFARCTION

Part ii. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical axaminar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describa how injury occurrad

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar: [signature]

29c. Licansa number: D27157

29d. Data signed *(Month, Day, Yaar)*: JANUARY 5, 1997

30. Nama and address of parson who completad causa of daath (Item 23a) (Type, Print): RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 09 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

97-0071-005

B.K.S ITEMS· 23 PART I, II, 27,
PER MEO FILM G-744 2/3/97 tt

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA ELLIS
2. Date of Death (Month, Day, Year): JAN. 5, 1997
3. Time of Death: 12:15AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-46-5955
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 18, 1948
9. Birthplace (State or Foreign Country): VA.

Usual Residence of Decadant

10a. State: Md
10b. County: N I A
10c. City, Town or Location: Balto
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4612 Wallington Ave apt D
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): 2yrs
16a. Dacadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): L.P.N.
16b. Kind of Business/Industry: Rosewood state Hosp.

17. Father's Name (First, Middle, Last): George Goodwin
18. Mother's Name (First, Middle, Maiden Surneme): Gladys Liggins

19a. Informant's Name/Raiationship (Type, Print): Kelly B. Goodwin - Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8517 Glen Michael Lane apt 102 Balto, md 21244

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other place): King Mem Pk
Data: 1/9/97
20c. Location - City or Town, State: Randallstown, md

21. Signature of Funeral Service Licensee: Shannon Stokes
22. Neme and Address of Facility: March F.H.-West 4300 Wabash Ave

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate intarval Between Onset end Deeth

Immediata Cause (Final disease or condition resulting in death)
a. MULTISYSTEM ORGAN FAILURE
Due to (or as a consequence of):
b. SEPSIS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last
Due to (or as e consequenca of):
c.
Due to (or es a consequence of):
d.

Part II. **Other eignificant conditfone** contributing to death but not resulting in the underlying causa given in Part I.

MORBID OBESITY; STATUS POST CECECTOMY, SMALL BOWEL RESECTION, SMALL BOWEL ENTEROTOMY

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? ☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: ☒1 Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: ☒1 Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how Injury occurred
28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Phyeician**: To tha best of my knowledge, daath occurred at the tima, date and place, and dua to tha cause(s) and mannar as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Aaron Locke MD
29c. Licensa number: O.C.M.E
29d. Data signed (Month, Dey, Year): JAN. 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 0 9 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Iris H. Esenwine

2. Date of Death Month: January Day: 07 Year: 1997

3. Time of Death: 5:55 P.M.

4a. Facility Name (If not institution, give street and number): 2012 Eastridge Road

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 219-22-5013

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 09,1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2012 Eastridge Road

10f. Zip Code: 21093

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 08 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): S. Roland Henry

18. Mother's Name (First, Middle, Maiden Surname): Estelle Wilkinson

19a. Informant's Name/Relationship (Type, Print): Mr. Ronald C. Esenwine (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2012 Eastridge Road Timonium, Maryland 21093

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify): Entombment

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Dulaney Valley Mem. Gard. Date: 01/10/97

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebral Vascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Prelmen

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D25686

29d. Date signed (Month, Day, Year): 1-8-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): EBRAHIM IPAKCHI MD 7600 OSLER DRIVE BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

4

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00267

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ulysses Gilliam

2. Date of Death Month: Jan Day: 3rd Year: 1997

3. Time of Death: 1:45 Am

4a. Facility Name *(If not institution, give street and number)*: Levindale

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 257-40-2936

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 28, 1931

9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: Md

10b. County: Balto

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8 Duke of Windsor Court

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade. College (1-4or 5+): 2 yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: Housing Authority

17. Father's Name *(First, Middle, Last)*: Ulysses S. Gilliam

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Hoff

19a. Informant's Name/Relationship *(Type, Print)*: Ruth Gilliam - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2416 W. Lanvale Street Baltimore, Md 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Date: 1-10-97

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson

22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. acute cardiopulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. arteriosclerotic cardiac disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cellulitis Hx. transient ischemic attack decubitus hypertension, diabetes obstructive Chronic pulmonary disease, peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Consuelo Moreno

29c. License number: D: 44907

29d. Date signed *(Month, Day, Year)*: Jan 7th 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Consuelo Moreno, MD 2434 W. Belvedere Ave Balto MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 1997

32. Registrar's Signature: Gale Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Greenberg
2. Date of Death: Month January Day 5 Year 1997
3. Time of Death: 11:40 pm.
4a. Facility Name (If not institution, give street and number): BROOKGROVE NURSING HOME
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 219-10-0392
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 18, 1909
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10224 PEANUT MILL DRIVE
10f. Zip Code: 20882
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUILDING INSPECTOR
16b. Kind of Business/Industry: BALTIMORE CITY GOVERNMENT

17. Father's Name (First, Middle, Last): MICHAEL GREENBERG
18. Mother's Name (First, Middle, Maiden Surname): DORA BAKER

19a. Informant's Name/Relationship (Type, Print): MR. MICHAEL S. GREENBERG (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10224 PEANUT MILL DRIVE GAITHERSBURG, MD 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHERNIGOVER
Date: 1-6-1997
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MYOCARDIAL INFARCTION — 2 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T E Howe
29c. License number: D33700
29d. Date signed (Month, Day, Year): JANUARY 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 18100 SLADE SCHOOL ROAD, SANDY SPRING, MD 20860

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00269

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): CHARLES H. HOFFBERGER

2. Dete of Deeth: Month JANUARY Day 5 Year 1997

3. Time of Death: 12:53 PM

4e. Facility Name (If not institution, give street and number): 3513 WOODVALLEY DRIVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-10-9718

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): JAN 6, 1912

9. Birthplece (State or Foreign Country): MARYLAND

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Insida City Limita: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3513 WOODVALLEY DRIVE

10f. Zip Code: 21208

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yaa 2 [X] No If Yas, Give Yeer or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, apecify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Spacify:

14. Race - Amarican Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elamantary/Secondary (0-12): Collega (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CHAIRMAN OF BOARD

16b. Kind of Business/Industry: WAREHOUSING COLD STORAGE

17. Father's Nema (First, Middle, Last): HARRY HOFFBERGER

18. Mother's Neme (First, Middle, Meidan Surname): MOLLIE KRIEGER

19a. Informant's Neme/Relationship (Type, Print): MRS. FLORENCE HOFFBERGER (WIFE)

19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 3513 WOODVALLEY DRIVE BALTIMORE, MD 21208

20e. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetary, crematory or other piece): CHIZUK AMUNO - Dete: 1-6-1997

20c. Location - City or Town, Stata: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Michael Bruger

22. Nama and Address of Facility: SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Part I. Enter tha diaeese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heert feilura. List only one cause on aach line.

Approximete Interval Between Onset and Death

Immedieta Ceuse (Finel diseese or condition resulting in deeth):
a. CEREBRO VASCULAR ACCIDENT — ~ 10 Min

Due to (or es a consequance of):
b. ATHEROSCLEROTIC CEREBRO VASCULAR DISEASE — ~ 8 YEARS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted eventa resulting in deeth) Last

Dua to (or as a consequence of):
c.

Dua to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

RENAL FAILURE

ABDOMINAL AORTIC ANEURYSM

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to compilation of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Plece of Deeth (Check only ona)

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Homa 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Mark M Brookfield MD

29c. License number: D02512

29d. Deta signed (Month, Day, Year): 1/5/97

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): MARK M BROOKFIELD MD MERCY MEDICAL CENTER 301 St Paul Balto 21202

State Registrar

31. Deta filed (Month, Day, Year): JAN 09 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00270

ITEM: 1 per FH 1-9-97 G-743 eoh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILDE HENRIETTA JACOB
2. Date of Death Month Day Year: JANUARY 2 1997
3. Time of Death: 2:55 PM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 090-11-9480
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT.18,1908
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD
10b. County: HARFORD
10c. City, Town or Location: BEL AIR
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 800 COCONUT CT., APT. A
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): BERTRAM SCHULHAUS
18. Mother's Name (First, Middle, Maiden Surname): BETTINA OPPENHEIMER

19a. Informant's Name/Relationship (Type, Print): FRED JACOB (HUS.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 COCONUT CT., APT. A BEL AIR, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): CHEVRA AHAVAS CHESED
Date: 1/3/1997
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Gary Fox
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RENAL FAILURE
Due to (or as a consequence of):
b. DEHYDRATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DEMENTIA
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D44560
29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 16755 FALLS RD SUITE 460 LUTHERVILLE, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00271

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bessie E. Johnson

2. Date of Death Month: January Day: 5 Year: 1997

3. Time of Death: 6.45 p.m.

4a. Facility Name *(If not Institution, give street end number)*: 1202 North Dukeland Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 242-16-8689

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 7, 1912

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1202 n. Dukeland st.

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedant's Education *(Specify only highest grade completed)*

Elamantery/Secondary (0-12): 9th

Collage (1-4or 5+): N/A

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: assembler

16b. Kind of Business/Industry: Md. Cup Corp.

17. Fathar's Neme *(First, Middle, Last)*: George Brown

18. Mother's Neme *(First, Middle, Meidan Surneme)*: Mary Poole

19a. Informant's Neme/Reletionship *(Type, Print)*: Curley Jones. Daughter

19b. Mailing Addrass *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 25 Sunrise ct Balto, md 21133

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cematary, cremetory or other piece)*: md national mem Pk.

Dete: 1/9/97

20c. Location - City or Town, State: Laurel, md

21. Signature of Funeral Service Licensee: Sharon Stokes

22. Name end Address of Facility: Mach F.H.-West 4300 Wabash Ave

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the moda of dying, such es cardiac or respiretory errest, shock, or heert feilura. List only ona cause on eech lina.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic squamous cell cancer — 9months

Due to (or as e consaquenca of):

Sequentielly list conditions, if eny, leeding to immediete causa. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of *my* knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the besis of examinetion end/or investigetion, in *my* opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end *menner* steted.

29b. Signature and title of certifier: Kristine Bienvenu MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: January 6 1997

30. Nema and eddress of person who completed causa of deeth (Item 23a) (Type, Print): Kristine Bienvenu, 720 Rutland Avenue, Johns Hopkins Hospital, Baltimore, Maryland

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 0 9 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00272

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: HUBERT LAMB

2. Deta of Death Month JANUARY Dey 7 Year 1997

3. Time of Death: 4:45 pm

4e. Facility Neme *(If not institution, give street end number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 246 48 4939

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY5,1927

9. Birthplece *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10e. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: COCKEYSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1 NUTMEG KNOOL COURT APT. C

10f. Zip Code: 21030

10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: DEPT. OF STATE HIGHWAY COMMISSION

17. Father's Neme *(First, Middle, Last)*: NAMON LAMB

18. Mother's Neme *(First, Middle, Meiden Surneme)*: MARY LAMB

19e. Interment's Neme/Reletionship *(Type, Print)*: TWYLER LAMB (DAUGHTER)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1 NUTMEG KNOLL CT. APT.C COCKEYSVILLE,MD. 21030

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: UNION CHAPEL CHURCH CEM.

Dete: 1/11/97

20c. Location - City or Town, Stete: SAMPSON CO.,N.C.

21. Signature of Funerel Service Licensee: LEWIS T. GWYNN — Lewis T Gwynn

22. Name and Address of Fecility: LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO.,MD.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert tellure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Respiratory Failure	7 days
Due to (or as a consequence of): b.	Pneumonia	30 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	lung Mass - unknown etiology	30 days
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stacey Anderson MD

29c. License number: D50746

29d. Date signed *(Month, Day, Year)*: January 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6565 N. Charles St #203 Baltimore, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 9 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0031-510
wlc

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00273

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAYWOOD LEWIS
2. Date of Death Month Day Year: January 2, 1997
3. Time of Death: 0930a
4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-58-4126
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01/04/1953
9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 306 N. Culver Street
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 9/28/70 4/14/72
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver
16b. Kind of Business/Industry: Cab
17. Father's Name *(First, Middle, Last)*: Nathaniel Lewis
18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Bishop
19a. Informant's Name/Relationship *(Type, Print)*: Muriel Lewis
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 306 N. Culver Street, Balto., MD 21229
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet. Cem. — Date: 1/8
20c. Location - City or Town, State: Owings Mills, MD
21. Signature of Funeral Service Licensee: Leroy O. Dyett
22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Print. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Drowning

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 01-02-97
28b. Time of Injury: 0820a M
28c. Injury at Work? 1 [ ] Yes [X] No
28d. Describe how injury occurred: Decedent jumped into water
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Inner Harbor
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 403 E. Pratt Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen R. Nacht, M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

3

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 1997
32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALEX LEFKOWITZ
2. Date of Death (Month, Day, Year): JAN. 5, 1997
3. Time of Death: 12:50am
4a. Facility Name (If not institution, give street and number): MULTI MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 065-09-0921
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 12, 1906
9. Birthplace (State or Foreign Country): HUNGARY

Usual Residence of Decedent

10a. State: FLORIDA
10b. County: DADE
10c. City, Town or Location: NORTH MIAMI BEACH
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 445 N.E. 195th APT. 424
10f. Zip Code: 33179
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INTERIOR DECORATOR
16b. Kind of Business/Industry: INTERIOR DESIGN

17. Father's Name (First, Middle, Last): IGNATZ LEFKOWITZ
18. Mother's Name (First, Middle, Maiden Surname): SARAH UNKNOWN

19a. Informant's Name/Relationship (Type, Print): MRS. ELEANOR SOLOMON (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 GROSVENOR CT. REISTERSTOWN, MD 21136

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HAR SINAI
Date: 1-8-1997
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Ellensue Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — hours

Due to (or as a consequence of):
b. Enterovesicle Fistula — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: no Medical Attendant
29c. License number: D17118
29d. Date signed (Month, Day, Year): 1/6/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 4000 Old County Rd Suite 203 Lutz FL 33549

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00275

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BEVERLY E. LEVIN
2. Date of Death Month Day Year: JANUARY 6, 1997
3. Time of Death: 7:10pm
4a. Facility Name *(If not institution, give street and number)*: 6106 IVYDENE TERRACE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-20-9345
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APR. 4, 1925
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residance of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6106 IVYDENE TERRACE
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indian, Bieck, White, etc. *Specify:* WHITE

15. Decedent's Eddcetion *(Specify only highest grede completed)*: Elamentery/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa ratired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JACOB J. EDELMAN
18. Mother's Nema *(First, Middle, Meiden Surname)*: GERTRUDE BLEIBERG

19a. Informent's Neme/Reletionship *(Type, Print)*: JUDGE MARSHALL A. LEVIN (HUSBAND)
19b. Meiling Addrass *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 6106 IVYDENE TERRACE BALTIMORE, MD 21209

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Spacify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: ANSHE EMUNAH (AITZ CHAIM) Date: 1-8-1997
20c. Location - City or Town, Stete: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Michael Kruger
22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceusad the daath. Do not antar the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Metastatic Breast Carcinoma — 5yrs

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest:
b.
Due to (or es e consequance of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cauas of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings avellable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et tha time, date and piece, end due to the cause(s) and mennar as stated. 2☐ **Medical Examiner**: On the besis of examinetion end/or investigetion, in my opinion, daeth occurrad et the time, dete end piece, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Marshall A. Levine
29c. License number: D17873
29d. Date signed *(Month, Day, Year)*: 1/7/97

30. Nama end address of person who completed causa of daath (Item 23a) (Type, Print): Marshall A. Levine 4000 Old Court Rd. Suite 306 Baltimore, MD 21208

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 09 1997
32. Registrar's Signeture: Julie Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS PAUL LEVIN
2. Date of Death Month Day Year: JAN. 7, 1997
3. Time of Death: 5:18am
4a. Facility Name (If not institution, give street and number): 4014 ELMORA AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-32-1317
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 18, 1905
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4014 ELMORE AVE.
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: UNKNOWN
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED
16b. Kind of Business/Industry: PAPER HANGER

17. Father's Name (First, Middle, Last): JOSEPH DAVID LEVIN
18. Mother's Name (First, Middle, Maiden Surname): IDA SILVER

19a. Informant's Name/Relationship (Type, Print): MR. LEON LEVIN (BROTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3218 SMITH AVE. BALTIMORE, MD 21208

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): TIFERETH ISRAEL -
Date: 1-8-1997
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Michael Singer
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic heart disease	10 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Friedman MD
29c. License number: D01103
29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Ronald Friedman MD 23 Crossroads Dr. - Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

WRC
97-0087-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00277

ITEMS: 4b,19b per F.H. G-743 1/9/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRIETTA MITCHELL
2. Date of Death (Month, Day, Year): JAN. 05, 1997
3. Time of Death: 11:00 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN ~~BALTIMORE~~
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-07-8941
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/21/1905
9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedant

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3635 Eitemiller Road
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grada complated): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Housewife
16b. Kind of Business/Industry: In Home

17. Father's Name (First, Middle, Last): Horace Smith
18. Mother's Nama (First, Middle, Maidan Surname): Ella Smith

19a. Informant's Name/Relationship (Type, Print): Willie Mitchell, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 3919 ~~Princley~~ PRINCELY Way, Baltimore, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Western Star Cemetery
Data: 1/10
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Leroy O. Dyett
22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE.,BALTO. 21207

Physician /Medical Examiner

23a. Rarti. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilura. List only one cause on each line.

Approximata Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Dua to (or as a consequence of):

Saquentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last:
b. Dua to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? HOSP ONLY 1☒ Yes 2☐ No
24b. Were autopsy findings avaliabla prior to completion of cause of daath? 1☒ Yes 2☐ No

25. Was case raferred to medical examiner? 1☒ Yes 2☐ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 8☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowladga, daath occurred at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☒ **Medical Examinar:** On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Maynie McKnell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JAN. 06, 1997

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): MARYANN D. KOBOSKI MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: ▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 1,8,14 per Fh g743 1-30-97 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00278

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY A. MORSELL

2. Date of Death: Month January Day 6, Year 1997

3. Time of Death: 12:15 A.M.

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Balto

Funeral Director

5. Social Security Number: 526-20-5854

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 15, 1918

9. Birthplace (State or Foreign Country): MEXICO ~~CALIFORNIA~~

Usual Residence of Decedent

10e. State: md

10b. County: NIA

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5362 King Arthur circle

10f. Zip Code: 21237

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) XX1☒ Yes 2☐ ~~No~~ Specify: Mexican

14. Raca - American Indian, Black, White, atc. Specify: Mexican Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+): NIA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John Smith

18. Mother's Name (First, Middle, Maiden Surname): Carmen Ramos

19a. Informant's Name/Relationship (Type, Print): Lowndnes Morsell-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2232 Sidney Ave Balto, md 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet

Date: 1/10/97

20c. Location - City or Town, State: Owings Mills, md

21. Signature of Funeral Service Licensee: Portia Elvron

22. Name and Address of Facility: Marsh F.H. west 4300 Wabash Ave

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CANCER, UNKNOWN — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: FAILURE TO THRIVE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kendall Faulkner

29c. License number: D25643

29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marguerite C. Ringgold
2. Date of Death: Month Jan Day 4 Year 1997
3. Time of Death: 5:00pm
4a. Facility Name (If not institution, give street and number): 632 Reckord Rd
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-28-8164
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 5, 1928
9. Birthplace (State or Foreign Country): Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 632 Reckord Rd
10f. Zip Code: 21047
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bieck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12th | College (1-4or 5+): 3 1/2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educatimal Assistant
16b. Kind of Business/Industry: Balto City Schools

17. Father's Name (First, Middle, Last): John W. Levere
18. Mother's Name (First, Middle, Maiden Surneme): Marguirette Harvey

19a. Informant's Neme/Relationship (Type, Pnint): Albert G. Ringgold Sr. Husband
19b. Meiling Address (Street end Number or Rbral Route Number, City or Town, State, Zip Code): 632 Reckord Rd Fallston, md 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piace of Disposition (Neme of cemetery, cremetory or other pieca): Dulaney Valley Mem Gardens
Date: 1/11/97
20c. Location - City or Town, Stete: Towson, md

21. Signature of Funeral Service Licensee: Pattie Elton
22. Name and Address of Facility: March F. H. West 4300 Wabash Avenue Balto md 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused tha deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haert feiiure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death): a. GLIOBLAST-MS — 1 YEAR

Due to (or es e consequence of):

Sequentially list conditions, if ery, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Othar (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end pieca, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete and piaca, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier
29c. License number: D22545
29d. Dete signed (Month, Day, Year): 1-8-97

30. Neme and addrass of person who completed cause of deeth (Item 23a) (Type, Print): 2300 York Road Timonium, md

State Registrar

31. Dete filed (Month, Day, Year): JAN 09 1997
32. Registrer's Signature: Julia Davidson-Ramsey

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS CATE RHINE
2. Date of Death Month Day Year: JANUARY 7, 1997
3. Time of Death: 6:37PM
4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON, MARYLAND
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-10-6322
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1908
9. Birthplace (State or Foreign Country): Al.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Rd.
10f. Zip Code: 21286
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Buyer
16b. Kind of Business/Industry: Hutzler Brothers

17. Father's Name (First, Middle, Last): Thomas M. Cate
18. Mother's Name (First, Middle, Maiden Surname): Josephine Crandall

19a. Informant's Neme/Relationship (Type, Print): Dorothy C. Brown/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8800 Walther Blvd. #3214 Parkville, Md. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns. | Date: 1/11/97
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Complete pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIOGENIC SHOCK — 2 DAYS

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest:
b. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 30263
29d. Date signed (Month, Day, Year): 1-8-97

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): FRANCIS KHOO, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

12

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00281

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys I. Scott

2. Date of Death (Month, Day, Year): January 6, 1997

3. Time of Death: 1:10 P.M.

4a. Facility Name *(If not institution, give street and number)*: 14302 Robcaste Road

4b. City, Town, or Location of Death: Phoenix

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 229-32-7700

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 22, 1917

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Phoenix

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14302 Robcaste Road

10f. Zip Code: 21131

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 yrs. College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: William Irwin

16. Mother's Name *(First, Middle, Maiden Surname)*: Charlotte Farmer

19a. Informant's Name/Relationship *(Type, Print)*: Mr. William Scott Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14308 Robcaste Road Phoenix, Maryland 21131

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 1/7/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Earl L. Ruck

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Rhumatoid arthritis — Approximate Interval: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: osteoporosis; F Dx

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

26e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark Lamos

29c. License number: D35521

29d. Date signed *(Month, Day, Year)*: 1-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark A. Lamos, M.D. 9 Schilling Road Hunt Valley, Maryland 21031

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Part I. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

RKD

97-0109-005

ITEMS: 23 PART I, 27, PER MEO

FILM g-743 1/27/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
THOMAS	V.	SPADARO	JANUARY	6,	1997	0704 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4 FLANDERS RIDGE COURT	HUNT VALLEY	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-50-0434	1☒M 2☐F	50 Yrs.					Nov. 20, 1946	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Cockeysville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4 Flanders Ridge Court	21030	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: Reserve	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Investor	Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Vincent A. Spadaro	Mary C. Sunderland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Mary C. Spadaro (Mother)	740 Camberley Circle Apt. A-3 Towson, Md. 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	1/9/97	Towson Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael J. Ruck	Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	JANUARY 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LALON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-0113-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS- 23 PART I, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene

FILM G-743 1/27/97 t.t

Certificate of Death

Reg. No. 97 00283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Year	3. Time of Death
CAROL	EILEEN	SPARKS	JANUARY 5, 1997	4:30P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
727 CHARING TERRACE	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
489-62-5706	1☐ M 2☒ F	43 Yrs.			Sept. 6 1953	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Towson	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
727 Charing Terrace	21204	USA

11. Meritai Stetus	12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Decadent of Hlspenlc Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decadent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+2	Medical Radiation Technologist	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
William S. Sparks	Joy E. Young

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William S. Sparks/Father	15401 E. 36th Terrace Independence,MO. 64055

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Hilltop Service Co.	1-8-97	Towson,Md.

21. Signeture of Funerei Service Licensee ▶ [signature]

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson,Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or comp[illegible]ations that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in death): e. MORBID OBESITY

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Deeth (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end manner es steted.

2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ [signature] J. Laron Locke MD	O.C.M.E.	JANUARY 7, 1997

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signeture
JAN 09 1997	[signature] Julie Davidson-Rumpleta

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence Washington
2. Date of Death: Month 1 Day 7 Year 1997
3. Time of Death: 7:45 PM
4a. Facility Name (If not institution, give street and number): Greenspring Nursing & Rehab Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-10-2853
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/20/1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4615 Park Heights Avenue
10f. Zip Code: 21215
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitorial Service
16b. Kind of Business/Industry: School System

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Nema (First, Middle, Meiden Sumeme): Winford Washington

19e. Informant's Neme/Reletionship (Type, Print): Clarice Washington
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3917 Dolfield Ave.,#2B, Balto., MD 21215

20e. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Garden of Eternal Hope
Date: 1/11
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Leroy O. Dyett
22. Nema and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207

Physician /Medical Examiner

23a. Part I. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in deeth) e.	CARDIAC ARRYTHMIA	ACUTE
Due to (or es e consequence of): b.	HYPERTENSIVE CARDIOVASCULAR DISEASE	YEARS
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest. Due to (or as a consequence of): c.	ESSENTIAL HYPERTENSION	YEARS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No N/A

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Robert E. Rolyns MD
29c. License number: D-19425
29d. Dete signed (Month, Day, Year): 1/08/97

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): 4615 PARK HGTS. AVE BALTIMORE MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00285

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hildegard Albert

2. Date of Death (Month, Day, Year): January 6, 1997

3. Time of Death: 12:15A

4a. Facility Name (If not institution, give street and number): Roland Park Place

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-82-9368

6. Sex: 1☐ M 2☐ F XXX

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 25, 1910

9. Birthplace (State or Foraign Country): Austria

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No XXX

10e. Street and Number: 830 West 40th Street

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Meritel Status: 1☐ Never Married 2☐ Married XXX Widowed 4☐ Divorced

12. Wes Decedant Ever in U.S. Armed Forces? 1☐ Yas XXX No If Yas, Giva Year or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1☐ Yas XXX No Specify:

14. Rece - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highest grada completed)

Elemantary/Secondery (0-12):

College (1-4or 5+): 2

16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired): Teacher

16b. Kind of Businass/Industry: Piano

17. Fathar's Nama (First, Middle, Last): Joseph Emil Janousek

18. Mothar's Nama (First, Middle, Meiden Surnama): Viktoria Stadler

19a. Informant's Name/Ralationship (Type, Print): Larry J. Albert Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 6404 Pinehurst Road Baltimore, Maryland 21212

20a. Mathod of Disposition: 1☐ Burial 2XXX amation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemetery, cramatory or other place): Greenmount Cemetery

Data: 1/7/97

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Dennis Stephen Kenaker

22. Nama and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complicetions that caused the daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on aach lina.

Approximata Interval Batween Onsat and Death

Immediata Causa (Final diseese or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 5 YR

Dua to (or as a consequance of):

Sequentially list conditions, if eny, leading to immediata causa. Entar Underlying Cause (Disaasa or Injury that initiated evanta rasulting in death) Last

b.

Dua to (or es a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Ware autopsy findings avellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☐ No

26. Placa of Death (Check only ona)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residance 6☐ Othar (Specify)

27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier:

29c. License number: 023319

29d. Date signed (Month, Day, Year): January 6, 1997

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Nathan M. Rosenblum 7600 Osler Drive Towson, Md 21204 Suite 106

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Submit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma Eugene Ackman

2. Data of Death Month Day Yaer: Jan 9, 1997

3. Tima of Death: 9:00 A.M.

4a. Facility Neme (If not institution, giva street and number): 9615 Orpin Road Apt. 104

4b. City, Town, or Location of Death: Randallstown

4c. County of Deaih: Baltimore

Funeral Director

5. Social Security Number: 214-24-7871

6. Sex 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth (Month, Day, Year): Feb 5, 1925

9. Birthplaca (Stata or Foreign Country): Maryland

Usual Rasidance of Dacadant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Insida City Limits 1☐ Yes 2☒ No

10e. Street and Number: 9615 Orpin Road Apt. 104

10f. Zip Coda: 21133

10g. Citizan of What Country?: U.S.A.

11. Maritei Stetus: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indian, Black, White, atc. Specify: White

15. Dacedant's Educetion (Specify only highast grade compiated): Elamantary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fethar's Nama (First, Middla, Last): Wilbur Bonsal

18. Mothar's Nama (First, Middla, Maidan Surnama): Ruth Johnson

19a. Informant's Name/Raiationship (Typa, Print): Mr. Kenneth Ackman

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 10727 Davis Avenue Woodstock, MD 21163

20a. Method of Disposition 1☐ Burial 2☒ Cramation 3☐ Ramovai from Stata 4☐ Donation 5☐ Othar (Spacify)

20b. Piace of Disposition (Nama of cematary, crematory or othar piece): Carroll Cremation Serv. Data: Jan. 10, 1997

20c. Location - City or Town, Stata: Hampstead, MD

21. Signature of Funaral Service Licensaa: Stephen M Jenkins

22. Nama and Addrass of Fecility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Death: 4 X BS

Immadiata Causa (Finai disease or condition resulting in death)

a. BREAST CANCER

Dua to (or as a consaquance of):

Sequantially list conditions, if any, laading to immadieta ceusa. Entar Underlying Ceusa (Disaasa or injury that initiated avants resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings avaliabla prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Rasidance 6☐ Othar (Specify)

27. Mannar of Death 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician**: To tha bast of my knowladga, daath occurred at tha tima, data and piece, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and piace, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar

29c. Licanse number: D35606

29d. Date signed (Month, Day, Year): 1/10/97

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): SAMUEL ZYDECK 21 CROSSROADS DR #415 OWINGS MILLS MD 21117

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signatura: Julia [illegible]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 4c, per F.H. G-743 1/10/97 reb

Certificate of Death

Reg. No. 97 00287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Renato Aragon

2. Date of Death: Month: JaNuary Day: 06 Year: 97

3. Time of Death: 9 30 am

4a. Facility Name (If not institution, give street and number): university of Maryland Medical Systems

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: ~~Baltimore City~~ N/A

Funeral Director

5. Social Security Number: 219-96-9745

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 28, 1956

9. Birthplace (State or Foreign Country): Phillipines

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3915 Setonhurst Rd.

10f. Zip Code: 21208

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): ; College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Napoleon Aragon

18. Mother's Name (First, Middle, Maiden Surname): Florencia Depante

19a. Informant's Name/Relationship (Type, Print): Marissa Alfaro (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 900 Sedley Rd. Virginia Beach, VA 23462

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park

Date: 1-8-97

20c. Location - City or Town, Stete: Sykesville, MD

21. Signature of Funeral Service Licensee: John K Aragon

22. Name end Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

e. malignant intracranial hypertension — ~36 hours

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

b. intracranial ruptured aneurysm — ~36 hours

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertension

renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier

29c. License number: P10036

29d. Date signed (Month, Dey, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barbara E Luzio MD, 22 S. Greene st. Baltimore MD 21201

State Registrar

31. Dete filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: John Littleton Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 3. PER DR. FILM G-743
1/10/97 t.t

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Joseph Adolfo
2. Date of Death (Month, Day, Year): Jan. 4, 1997
3. Time of Death: UNKNOWN
4a. Facility Name (If not institution, give street and number): 7849 Bank Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-30-2119
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 27, 1934
9. Birthplace (State or Foreign Country): MAryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7849 Bank Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Bernardino Adolfo
18. Mother's Name (First, Middle, Maiden Surname): Caroline Wilkinson

19a. Informant's Name/Relationship (Type, Print): Hilda Adolfo / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7849 Bank Street Balitmore Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 1/7/97
20c. Location - City or Town, State: Balitmore Md.

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave, Balitmore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. metastatic lung cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ASSIST. PROFF DEPT OF RADIATION ONCOLOGY
29c. License number: D47618
29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAN SUNTHARAM MD 22.5 GREENE ST BALT MD 21230

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julie Hutchison-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00289

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Adeline Bass

2. Date of Death Month: JAN Day: 08 Year: 1997

3. Time of Death: 10:20 PM

4a. Facility Name *(If not institution, give street and number)*: Caton Manor Genesis Eldercare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-12-2135

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR 26, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3330 Wilkens Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Person

16b. Kind of Business/Industry: Sears/Catalog Dept.

17. Father's Name *(First, Middle, Last)*: James C. Jacobs

18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle Emerick

19a. Informant's Name/Relationship *(Type, Print)*: Ronald W. Bass/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 520 S. Hanover St. Baltimore, MD 21201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: Epiphany Episcopal Church Cemetery — Date: 1/11/97

20c. Location - City or Town, State: Odenton, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald — Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ALZHEIMERS DISEASE — 5yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC LYMPHOCYTIC LEUKEMIA.

A.S.C.V.D

N I D D M.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Ramasesha, MD.

29c. License number: D17753

29d. Date signed *(Month, Day, Year)*: 1/09/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S. DHARMASENA, MD. 710 CHURCH ST. BALTIMORE, MD 21225

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Lucien-Randall

DHMH 16 Rev 6/95

(5)

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00290

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Donald Barrett

2. Date of Deeth: Month 1 Dey 8 Yeer 1997

3. Time of Death: 4:00 AM

4a. Facility Neme (If not institution, giva street and number): Greenspring Nursing & Rehab Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-18-6132

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthdey): 75 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): May 4, 1921

9. Birthpiece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4615 Park Heights Avenue

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yas 2☐ No If Yes, Give Yaer or Dates: 11-42,10-45

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

18b. Kind of Business/Industry: Industrial

17. Fathar's Nama (First, Middle, Last): Charles Carroll Barrett

18. Mother's Neme (First, Middle, Meiden Surnama): Edna Maul Wertz

19e. Interment's Neme/Reietionship (Type, Print): John C. Barrett (son)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 11 Eastford Ct. Baltimore, Maryland 21234

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Green Mount Crematory | Dete: 1-9-97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: George Ferrara

22. Neme end Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet causad tha death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deth

Immediate Ceuse (Finel diseesa or condition resulting in death):
a. ACUTE RESPIRATORY FAILURE — HOURS

Due to (or es e consequence of):
b. Chronic obstructive lung disease — YEARS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest:

Due to (or es e consequence of):
c. METABOLIC ENCEPHALOPATHY — WEEKS

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of causa of desth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

28. Plece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Phyaician**: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) and manner ss stated. 2☐ **Medical Examinar**: On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and piece, snd due to the cause(s) end menner steted.

29b. Signeture and title of certifier: B C Veneracion JR MD PA

29c. License number: D13664

29d. Data signed (Month, Dey, Year): Jan 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. C. VENERACION JR MD 1576 MERRITT BLVD, STE 22 BALTO MD 21222

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 1997

32. Registrer's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00291

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emory T. BERGQUIST
2. Date of Death Month Day Year: January 8, 1997
3. Time of Death: 4:10 pm
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-14-1193
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov.10,1912
9. Birthplace *(State or Foreign Country)*: Pittsburgh,PA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9920 Pepper Hill Road
10f. Zip Code: 21128
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: ? to 1/15/46
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yea, apecify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yea 2 [X] No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th. | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction Inspector
16b. Kind of Business/Industry: Dept.of Army Aberdeen Prov.

17. Father's Name *(First, Middle, Last)*: Walter Bergquist
16. Mother's Name *(First, Middle, Maiden Surname)*: Estella Boyle

19a. Informant's Name/Relationship *(Type, Print)*: Florence C. Bergquist (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9920 Pepper Hill Rd. Perry Hall, Md. 21128

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St.John's Episcopal Church Cem.
Date: Jan.11,1997
20c. Location - City or Town, Stete: Kingsville,Md. 21087

21. Signature of Funeral Service Licensee: E. F. Lassahn Funeral Home
22. Name end Address of Facility: E. F. Lassahn Funeral Home 11750 Belair Road Kingsville,Maryland 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediete Cause (Finai disease or condition resulting in death): a. Pneumonia — 5 days

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated eventa resulting in deeth) Lest:
b. End Stage Rheumatoid Lung Disease

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peritonitis; Perforated Segmoid Colon

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Waa an autopsy performed? 1 [ ] Yea 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
26e. Place of injury - At home, ferm, atreet, factory, office building, etc. *(Specify)*
26f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(a) end manner stated.

29b. Signature end title of certifier: Marco Zamora MD
29c. License number: D40819
29d. Date aigned *(Month, Day, Year)*: January 8,1997

30. Neme and address of person who completed cause of death (item 23e) (Type, Print): Marco Zamora M.D. 2303 Kings Arms Drive Fallston Maryland 21047

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 1 0 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAURA J. BURKE
2. Date of Death: Month JANUARY Day 6 Year 1997
3. Time of Death: 9:37 P
4a. Facility Name (If not institution, give street and number): Laurel Reginal Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 221-09-4583
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/14/1907
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Delaware
10b. County: Sussex
10c. City, Town or Location: Bridgeville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: R.D. 2, Box 25
10f. Zip Code: 19933
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamtress
16b. Kind of Business/Industry: District of Columbia

17. Father's Name (First, Middle, Last): Harry (NMI) Messick
18. Mother's Name (First, Middle, Maiden Surname): Mary Ann Willey

19a. Informant's Name/Relationship (Type, Print): Mary Ann Merson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1018 Turney Avenue - Laurel, MD 20707

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington Cemetery
Date: 01/10
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Howard C. Hardesty
22. Name and Address of Facility: Hardesty Funeral Home- 202 Laws Street Bridgeville, DE 19933

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hemorrhage, Intracranial — 5 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Kundert M.D.
29c. License number: D36716
29d. Date signed (Month, Day, Year): JANUARY 7TH, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW KUNDERT, M.D. 8317 CHERRY LANE, LAUREL, Md. 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Attending Physician: The law requires that the death certificate be executed within 24 hrs after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00293

Item: 4c, per F.H. G-743 1/10/97 reb *Certificate of Death* Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret R. Baker

2. Date of Death Month: January Day: 7 Year: 1997

3. Time of Death: 5 AM

4a. Facility Name (If not institution, give street and number): Long Green Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: ~~Baltimore City~~ N/A

Funeral Director

5. Social Security Number: 216-46-3937

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 6, 1903

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☒ Yes 2☐ No

10e. Street and Number: 115 E. Melrose Avenue

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Clerk

16b. Kind of Business/Industry: Family Store

17. Father's Name (First, Middle, Last): Alfred Purcell Rehbein

18. Mother's Name (First, Middle, Maiden Surname): Margaret Williams

19a. Informant's Name/Relationship (Type, Print): Lawrence Benton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1201 W. Lake Avenue, Baltimore, Maryland 21210

20a. Method of Disposition: X☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Poplar Grove Cemetery Date: 1/9

20c. Location - City or Town, State: Cockeysville, Maryland

21. Signature of Funeral Service Licensee: Lynn Burgee Henss

22. Name and Address of Facility: Burgee-Henss Funeral Home 21211, 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Hypertrophic Arteriosclerotic Cardio Renal Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. O'Donnell MD

29c. License number: 23-09383

29d. Data signed (Month, Day, Year): 1-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD - 111 Hamlet Hill Rd - Baltimore Md 21210

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997

32. Registrar Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within [illegible] after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00294

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Walter Burns

2. Date of Death Month: Jan Day: 6 Year: 97

3. Time of Death: 0230

4a. Facility Name *(If not institution, give street and number)*: Md General Hospital

4b. City, Town, or Location of Death: Balto

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 098-28-7748

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 6, 1935

9. Birthplace *(State or Foreign Country)*: G.A.

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 635 Aisquith St apt 10D

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unknown

16b. Kind of Business/Industry: Unknown

17. Father's Name *(First, Middle, Last)*: Willie Burns

18. Mother's Name *(First, Middle, Maiden Surname)*: Inez Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Andrew W. Burns Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 180 W. 15th place Pompano Beach Fla, 33060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: City of Pompano Beach cemetery

Date: 1/13/97

20c. Location - City or Town, State: Pompano Beach, Fla.

21. Signature of Funeral Service Licensee: Shannon Stokes

22. Name and Address of Facility: Main F.H. West 4300 Wabash Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Bowel obstruction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Adhesions

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Possible pulmonary embolus

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gerald M Hayward MD

29c. License number: D41836

29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gerald M. Hayward MD 4713 Leeds Ave Balt. MD 21227

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00295

ITEM#8 PER F.H. FLM#G749 7/30/97 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELSON EDWARD BURKE

2. Date of Death (Month, Day, Year): JANUARY 5, 1997

3. Time of Death: 6:25 AM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-28-5645

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~Aug. 29, 1933~~ 7-29-33

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 524 North Charles Street Apt. 1709

10f. Zip Code: 21201

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 Years

College (1-4 or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Exterminater

16b. Kind of Business/Industry: Pest Control

17. Father's Name (First, Middle, Last): William Francis Burke

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Wilson

19a. Informant's Name/Relationship (Type, Print): Martha R. Burke/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 524 North Charles St. Apt. 1709 Baltimore, MD 21201

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Garrison Forest V.A.Cem. Date: 01/09/97

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Johnny L Gibbs

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary Embolism.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 89261

29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Pornchai Jongkerthum, M.D. C/O Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: [signature] Lisa Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TIJUAN BELL-Parker

2. Date of Death: Month JANUARY Day 04 Year 97

3. Time of Death: 0015

4a. Facility Name (If not institution, give street and number): MERCY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-84-5630

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV.17,1962

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 26 S. EXETER ST. APT. 5B

10f. Zip Code: 21202

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): HERMAN BELL

18. Mother's Name (First, Middle, Maiden Surname): SHERRAN WISE

19a. Informant's Name/Relationship (Type, Print): ANTHONY PARKER- HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 S. EXETER STREET BALTO,MD. 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE CEMETERY

Date: JAN, 9 , 1997

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Jr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO,MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CANDIDEMIA — 9 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. ACQUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: THROMBOTIC THROMBOCYTOPENIC PURPURA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: P06829

29d. Date signed (Month, Day, Year): January 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THERESA LORCH MD 301 ST. PAUL PLACE BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Gwen Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Roland BOWEN
2. Date of Death (Month, Day, Year): January 7, 1997
3. Time of Death: 2:50 a.m.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-09-3290
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 13 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8820 Walther Blvd
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Howard Clay BOWEN
18. Mother's Name (First, Middle, Maiden Surname): Elsie COOK

19a. Informant's Name/Relationship (Type, Print): Janice M. Williams (niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Bristol Mill Ct."B-3" Catonsville, MD 21228

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, cremetory or other place): Loudon Park Mausoleum
Date: 1/10/97
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Jackie D. Shannon
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Ave, Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia Left Lower Lobe — 48 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Angina

Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard H Bond MD
29c. License number: D19793
29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Howard Bond M.D. 9618 Belair Road Baltimore, Maryland 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

97-0067-510

AM ITEMS: 23 PART I, 27, 28a-f,
PER MEO FILM g-743 1/14/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00298
Reg. No.

Physician /Medical Examiner

1. Decadent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey Year	3. Time of Death
ANGELO	CARTER	JAN.04,1997	2032 P

4a. Facility Neme (If not institution, giva street and numbar)	4b. City, Town, or Location of Death	4c. County of Deeth
JOHNS HOPKINS HOSPITAL ER	BALTIMORE	NA

Funeral Director

5. Sociel Security Number	6. Sax	7. Age (In yrs. lest birthday)	If Undar 1 Yaar Months	If Under 24 Hrs. Deys	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplece (Steta or Foreign Country)
215-52-0941	X☒M 2☐F	45 Yrs.					07-18-51	MD

Uauel Residenca of Decedent

10a. Steta	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Na	Baltimore	1☒Yes 2☐No

10e. Street end Number	10f. Zip Coda	10g. Citizen of Whet Country?
1612 E. Oliver Street	21213	USA

11. Maritel Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.)	14. Rece - American Indian, Bieck, White, atc.
1☐Never Merried 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Yeer or Datas:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grade completed)		16e. Decedent's Uauel Occupetion (Give kind of work done duning most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
12th Grade	2yrs.	Lab Technician	John Hopkins Hosp.

17. Fathar's Name (First, Middla, Last)	18. Mother's Name (First, Middle, Malden Surneme)
John Morton	Annie Carter

19e. Informent's Neme/Raiationahip (Type, Print)	19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code)
Annie Morton	1612 E. Oliver Street Baltimore, Md. 21213

20a. Mathod of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other pieca)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removei from Steta 4☐Donation 5☐Other (Specify)	Garrison Forest Va Cem	01-10-97	Owings Mills, Md

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ Sabrina M Adams	Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

29a. Part I. Enter the diseasa, or complicetions thet caused the deeth. Do not enter the moda of dying, such es cardiec or raspiratory arrest, shock, or heert feilura. List only one causa on eech line.

		Approximeta Interval Between Onset end Death
Immediete Ceuse (Finei diseese or condition resulting in deeth)	e. COCAINE AND NARCOTIC INTOXICATION	
	Due to (or as e consequance of):	
Sequantially list conditions, if eny, laeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted avanta rasulting in deeth) Last	b.	
	Due to (or es e consequenca of):	
	c.	
	Dua to (or es e consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☑Yes 2☐No	1☑Yes 2☐No

25. Wes case referred to medical examiner?	26. Piace of Deeth (Check only one)	
XXYes 2☐No	Hospitel: 1☐Inpatiant XXER/Outpetient 3☐DOA	Other: 4☐Nursing Homa 5☐Residenca 6☐Other (Specify)

27. Mennar of Death	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐Netural 2☐Accident 3☐Suicida 4☐Homicida 5☑Panding investigation 6XXCould not be datermined	FOUND 1/4/97	8:10 P M	1☐Yes 2XXNo	UNKNOWN

28e. Piaca of injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)
FOUND RESIDENCE	1612 S. OLIVER STREET BALTIMORE, MARYLAND

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and piece, and due to the causa(s) and mannar as stated. XX **Medical Examiner:** On the basis of axamination end/or investigation, in my opinion, daeth occurred et tha time, deta and piece, and dua to the cause(s) and menner steted.

29b. Signature end title of certifier	29c. License number	29d. Deta signed (Month, Day, Year)
▶ Wayne Price MD	OCME	JAN.05,1997

30. Name and eddress of person who complated cause of death (Item 23e) (Type, Print)
MARYSROSS A. KOKOSZ 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yaer)	32. Registrer's Signeture
JAN 10 1997	▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requiras thet the death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by tha attanding physician and completely filled in by the funaral director, page 2 should be detached for usa as the burial-transit

97-0084-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27,28a,b,c,d,e,f per MEO G-745 3/4/97 reb

Certificate of Death

Reg. No. 97 00299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEE ANN CORCORAN
2. Date of Death (Month, Day, Year): JAN. 5, 1997
3. Time of Death: 0912 AM
4a. Facility Name (If not institution, give street end number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-74-5558
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 10, 1959
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decadant

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2800 LINWOOD AVE
10f. Zip Code: 21234
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowad 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxtcan, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decadant's Education (Specify only highest grade completad): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CASHIER
16b. Kind of Business/Industry: GROCERY

17. Father's Neme (First, Middle, Last): JOSEPH BRAY CORCORAN, JR.
18. Mother's Name (First, Middle, Malden Surneme): PATSY LEE ALLEN

19a. Informant's Neme/Relationship (Type, Print): PATSY LEE CORCORAN/MOTHER
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 2800 LINWOOD AVE. BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): LOUDON PARK CEMETERY
Dete: JAN. 7, 1997
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funerel Servica Licantea: Alan C. Pierce
22. Neme and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVE BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not entar tha mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on eech line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel disaase or condition resulting in deeth): a. NARCOTIC AND COCAINE INTOXICATION COMPLICATING CIRRHOSIS OF THE LIVER

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlytng Cause (Diseese or Injury that initiated events rasulting in daath) Last:
Dua to (or as a consequance of):
b.
Dua to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☒ Yas 2☐ No
24b. Were autopsy findings availiable prior to completion of cause of deeth? 1☒ Yes 2☐ No

25. Was case refarred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☐ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☒ Could not be determined
28a. Date of Injury (Month, Dey Year): 1/5/97
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Dascribe how Injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home
28f. Location (Street end Number or Rural Route Number, City or Town, State): 2800 Linwood Ave Baltimore, Md.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha best of my knowledge, deeth occurred at the time, date and plece, and due to the ceuse(s) and menner as stated. 2☒ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the ceuse(s) end manner stated.
29b. Signature and title of certifier: Maryse Bellfield
29c. License number: O.C.M.E
29d. Date signed (Month, Dey, Year): JAN. 6, 1997

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): MARYSE D. BELFIELD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JAN 10 1997
32. Registrer's Signature: Lisa Davidson-Kendall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Changlin
2. Date of Death (Month, Day, Year): January 9, 1997
3. Time of Death: 1:54 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-5757
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 30, 1926
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4700 Mannasota Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Electric Company

17. Father's Name (First, Middle, Last): Joseph Ciancaglini
18. Mother's Name (First, Middle, Maiden Surname): Bambina Massa

19a. Informant's Name/Relationship (Type, Print): Lily Ciancaglini (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4700 Mannasota Avenue, Baltimore, Maryland 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem. 1-13
Date:
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40480
29d. Date signed (Month, Day, Year): JAN. 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FERNANDO J. FERRO, MD — 5810 BELAIR RD BALTO., MD 21206

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: [signature] Landson-Randolph

DHMH 16 Rev 6/95

WRC
97-0094-510

ITEMS: 23 PART I, 27, 28a-f, PER
MEO FILM g-743 1/15/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00301

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STERLING A. CARR

2. Date of Death: Month JAN. Day 06, Year 1997

3. Time of Death: 8:07 PM.

4a. Facility Name (If not institution, give street and number): 37 S. CAREY ST.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-58-4816

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 14,1953

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 906 W. Saratoga Street

10f. Zip Code: 21223

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Lighting

17. Father's Name (First, Middle, Last): Clifton E. Carr

18. Mother's Name (First, Middle, Maiden Surname): Leona Cornish

19a. Informant's Name/Relationship (Type, Print): Sherry Carr Jackson (Daug)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2918 Garrison Blvd Apt. T Balto, Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: 1/10/97

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Caple Funeral Service
5502 Winner Ave. Balto, Md. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE AT

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☑ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day, Year): FOUND 1-5-97

28b. Time of Injury: FOUND 8:00 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: UNKNOWN

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify): DWELLING

28f. Location (Street and Number or Rural Route Number, City or Town, State): 37 W. CAREY STREET BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JAN. 06, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARYANN B. KOREMAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FILM#G743
ITEM#1 PER. DOC. ITEM#7&8 PER F.H. 1-14-97 J.A.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty M. Clayton (AKA BESSIE)
2. Date of Death Month: 01 Day: 09 Year: 97
3. Time of Death: 5:05 a.m.
4a. Facility Name (If not institution, give street and number): Merridian Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-46-2375
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-4-35 3-6-38
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6605 Touchstone Ct.
10f. Zip Code: 21214
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 III; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): David Clayton
18. Mother's Name (First, Middle, Maiden Surname): Annie Clayton

19a. Informant's Name/Relationship (Type, Print): Maxine T. Jones - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6604 Touchstone Ct. Baltimore MD 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 1/13/97
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Albert P. Wylie FH PA 1238 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arreat, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GLIOBLASTOMA — 7 years
Due to (or as a consequence of):
Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was cese referred to madicel examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datermined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and place, and due to the ceuse(a) and manner stated.

29b. Signature and title of certifier:
29c. License number: D44604
29d. Data signed (Month, Day, Year): 1/10/97

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael David Suter - 8100 Harford Road - Baltimore, MD 21214

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Bosson Castagna
2. Date of Death: Month: January Day: 8 Year: 1997
3. Time of Death: 4:30 p
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-54-3592
6. Sex: 1☐ M 2☐ F XXX
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 19, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XXX 1☐ Yes 2☐ No
10e. Street and Number: 4316 St Paul Street
10f. Zip Code: 21218
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married XXX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): William Bosson
18. Mother's Name (First, Middle, Maiden Surname): Margaret Rusk
19a. Informant's Name/Relationship (Type, Print): Joseph V Costagna Jr Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7030 Senalda Road Los Angeles California 90068
20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crametory or other place): Dulaney Valley Memorial
Date: 1/11/97
20c. Location - City or Town, State: Lutherville, Maryland
21. Signature of Funeral Service Licensee: Dennis L Kenakes
22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Myocardial infarction	2 weeks
Due to (or as a consequence of):	b. Heart failure	2 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Z. Mumbwani MD
29c. License number: P09301
29d. Date signed (Month, Day, Year): January 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zattam Musselmani Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julia Strickler Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

90

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Collins
2. Date of Death Month: January Day: 4 Year: 1997
3. Time of Death: 1800
4a. Facility Name (If not institution, give street and number): 3939 Southern Cross Dr
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-01-2137
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 4, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3939 Southern Cross Drive
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8th grade; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Boiler Engineer
16b. Kind of Business/Industry: Baltimore City Public Schools

17. Fether's Name (First, Middle, Last): Dan Collins
18. Mother's Name (First, Middle, Meiden Surname): Ida Tongue

19a. Informent's Name/Relationship (Type, Print): Floyd Brown
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3939 Southern Cross Dr. Baltimore, MD. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Ptaca of Disposition (Name of cemetery, cremetory or other piece): Druid Ridge Cemetery
Dete: Jan 9 1997
20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Louis A Parker
22. Name end Address of Facility: Parker Funeral Home 3512 Frederick Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. Prostate cancer

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest:
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other stgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ tnpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of tnjury (Month, Dey Year)
28b. Time of tnjury M
28c. tnjury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete and piaca, and due to the cause(s) and menner stated.

29b. Signature and title of certifier
29c. License number: D35674
29d. Date signed (Month, Day, Year): January 7, 1997.

30. Name end address of perso who completed cause of deeth (Item 23e) (Type, Print): Wendell Clemmons, MD 4820 Seton Drive Suite A Baltimore Md 21215

State Registrar

31. Dete filed (Month, Day, Year): JAN 10 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00305

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carroll Patrick Copeland

2. Date of Death Month / Dey / Yeer: January 6, 1997

3. Time of Death: 10:30 PM

4a. Facility Name *(If not institution, give street end number)*: 2023 Codd Avenue

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 232-50-2579

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Oct. 23, 1934

9. Birthpleca *(Steta or Foraign Country)*: Kentucky

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Number: 2023 Codd Avenue

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Yaar or Datas: Korean

13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.): 1 ☐ Yas 2 ☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest greda completed)*: Elementery/Secondery (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steel Worker

16b. Kind of Business/Industry: Steel Industry

17. Fethar's Name *(First, Middla, Last)*: Wilber Copeland

18. Mother's Name *(First, Middle, Meiden Sumema)*: Biddie Vannatter

19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Donna M. Copeland/Wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2023 Codd Avenue Dundalk, Maryland 21222

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, cremetory or other place)*: Holly Hill Mem. Gdns. Data: 01/09/1997

20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Servise Licensee: ▶ Johnny L. Gibbs

22. Name end Address of Feciiity: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only ona cause on eech lina.

Approximate Interval Between Onset and Death

Immediata Ceuse (Finel diseese or condition resulting in deeth)

e. Metastatic Prostate Cancer — Due to (or es a consequenca of): — 7yrs.

Sequantially list conditions, if eny, leeding to immedieta cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

b. — Due to (or es e consequenca of):

c. — Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performad? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings evallable prior to completion of causa of deeth? 1 ☐ Yas 2 ☒ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☒ Residenca 6 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☒ Neturet 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et tha time, dete and pleca, end due to the cause(s) end manner as steted. 2 ☐ **Medicel Examiner**: On the besis of exemlnetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end dua to the cause(s) end manner steted.

29b. Signature end title of certifier: ▶ Wm C Waterfield MD

29c. License number: 024356

29d. Data signed *(Month, Day, Yeer)*: Jan 7, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Wm C WATERFIELD St Agnes Healthcare 900 Caton Ave Balt Md 21229

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 10 1997

32. Registrer's Signeture: Lelia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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97-0142-510
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27,28a-f per MEO G-746 4/24/97 reb

Certificate of Death

Reg. No. 97 00306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DARYL CROMWELL
2. Date of Death (Month, Day, Year): JANUARY 8 1997
3. Time of Death: 11:10AM
4a. Facility Name (If not institution, give street end number): 218 N. MADERIA STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-88-9695
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 26, 1963
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10e. State: MD
10b. County: NA
10c. City, Town or Location: BALTimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2115 Barclay Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ForkLift Driver
16b. Kind of Business/Industry: Shipyard

17. Father's Name (First, Middle, Last): Jerome Cromwell
18. Mother's Name (First, Middle, Maiden Surname): Rosetta Cromwell

19a. Informant's Name/Relationship (Type, Print): Gary Cromwell - Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 Village of Pine Ct. Apt 3C Baltimore, MD. 21244

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: 1-10-97
20c. Location - City or Town, State: BALTimore MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor Street Baltimore, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ~~End stage liver disease~~ NARCOTIC INTOXICATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
History of Endocarditis and Human Immunodeficiency Virus Seropositivity

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? Inspection 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: ~~1☐Natural~~ 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation XX☒Could not be determined

28a. Date of Injury (Month, Day Year): found 1/8/97
28b. Time of Injury: found 10:00 A M
28c. Injury at Work? 1☐Yes XX☒No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): at residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 218 N. Maderia St. Baltimore, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas M. Kiyuna
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 09, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE MIKING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: [signature]

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00307

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bradford Dean Cole

2. Date of Death Month Jan. Day 6, Year 1997

3. Time of Death: 8:15pm

4a. Facility Name *(If not institution, give street and number)*: 1402 E.W. Shady Side Road

4b. City, Town, or Location of Death: Shady Side

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-18-4467

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul. 2, 1921

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: 1402 E.W. Shady Side Road, Shady Side

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1402 E. W. Shady Side Road

10f. Zip Code: 20764

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone

16b. Kind of Business/Industry: C & P Telephone

17. Father's Name *(First, Middle, Last)*: Charles Augustas Cole

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Pedix

19a. Informant's Name/Relationship *(Type, Print)*: Doris Park Cole - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1402 E.W. Shady Side Rd. Shady Side, MD 20764

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: 1/10

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service License: Thomas N Hardesty

22. Name and Address of Facility: Hardesty Funeral HOme, P.A. 12 Ridgely Ave. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. PULMONARY FAILURE — 6 HRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 10 yrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harvey J Steinfeld

29c. License number: D0 5158

29d. Date signed *(Month, Day, Year)*: JAN 7 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARVEY STEINFELD, 6131 SHADYSIDE Rd. SHADYSIDE MD 20764

State Registrar

31. Date filed *(Month/Day, Year)*: JAN 1 0 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00308

ITEM: 29d per DR. G-743 1-10-97 eoh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LELA E CRAMBLITT

2. Date of Death: Month JAN Day 05 Year 1997

3. Time of Death: 01:06 AM

4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 219-18-9650

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 4, 1918

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3310 OLD FREDERICK ROAD

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOMEMAKING

17. Father's Name (First, Middle, Last): JIMMIE NEWSON

18. Mother's Name (First, Middle, Maiden Surname): MARY WHALEY

19a. Informant's Name/Relationship (Type, Print): EDNA RANCOURT (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3310 OLD FREDERICK ROAD - BALTIMORE, MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: 1/8/97

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Jackie N. Shannon

22. Name and Address of Facility: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS — ONE DAY

Due to (or as a consequence of):

b. CELLULITIS OF LEFT FOOT — ONE WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dafo MEDICAL RESIDENT

29c. License number: PD 9886

29d. Date signed (Month, Day, Year): JAN 05 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SETH OSAFO, ST AGNES HOSPITAL, 900 CATON AVE. BAL. MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Carlson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00309

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN CRAIG DAVIS
2. Date of Death Month: JANUARY Day: 7 Year: 1997
3. Time of Death: 11:16 PM
4a. Facility Name (If not institution, give street and number): Liberty Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 220-24-5285
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 17 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3611 Colpey Road
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Feb 52 Feb 53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker
16b. Kind of Business/Industry: Bethlehem Steel Corp.

17. Father's Name (First, Middle, Last): John Craig
18. Mother's Name (First, Middle, Maiden Surname): Catherine Davis

19a. Informant's Name/Relationship (Type, Print): wife Betty J. Davis
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3611 Copley Road Baltimore, MD 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): MD Veteran Cem/Garrison
Date: Jan 14
20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: Ernest R. Emery
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Morbid obesity

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G. Hartford, MD
29c. License number: D04826
29d. Date signed (Month, Day, Year): January 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. HARTFORD, MD Liberty Medical Center

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10/1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00310

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS WILLIAM DONNELLY
2. Date of Death (Month, Day, Year): January 7, 1997
3. Time of Death: 3:37 p.m.
4a. Facility Name (If not institution, give street and number): 1605 Cass Drive
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-30-3705
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 25, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1605 Cass Drive
10f. Zip Code: 21015
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1957-63
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Harold Donnelly
18. Mother's Name (First, Middle, Maiden Surname): Marie Clifford

19a. Informant's Name/Relationship (Type, Print): Ingeborg Donnelly (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1605 Cass Drive, Bel Air, MD. 21015

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.
Date: 1/11/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John T. Schimunek
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Metastatic alveolar cell lung cancer	~2yrs.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Chang, MD
29c. License number: D16587
29d. Date signed (Month, Day, Year): 1/8/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Paul Chang, MD 5601 Loch Raven Blvd, Balto, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 X 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00311

Film G743 item 1,8 per MEO &db 1-22-97 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): SAMUEL ~~DINNEYA~~ UGOCHUKWU DINNEYA

2. Dete of Deeth: Month JANUARY Dey 6, Yeer 1997

3. Time of Death: 5:30P.M.

4a. Fecility Neme (If not institution, give street end number): Prince George County Hospital

4b. City, Town, or Location of Deeth: Cheverly

4c. County of Deeth: Prince George

Funeral Director

5. Sociel Security Number: 459-71-7187

6. Sex: 1☒M 2☐F

7. Age (In yrs. lest birthdey): 37 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): ~~12-03-59~~ 03-12

9. Birthplece (Stete or Foreign Country): Nigeria

Usuel Residence of Decedent

10a. State: Md

10b. County: Prince George

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 5309 Riverdale Road Apt.#225

10f. Zip Code: 20737

10g. Citizen of What Country? USA

11. Meritel Status: 1☐Never Merried 2☐Merried 3☐Widowed 4☒Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Probation Officer

16b. Kind of Business/Industry: State of Maryland

17. Fether's Neme (First, Middle, Last): Enoch Ikwuegbu

18. Mother's Neme (First, Middle, Meiden Surname): Florence Ikwuegbu

19a. Informent's Neme/Relationship (Type, Print): Daniel Apugo

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1 Valdivia Court Apt.F Baltimore, Md. 21244

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)

20b. Ptece of Disposition (Neme of cemetery, cremetory or other piece): Ubakala Cem. Dete: 01-17-97

20c. Locetion - City or Town, Stete: Lagos, Nigeria

21. Signeture of Funerel Service Licensee: Timothy

22. Neme end Address of Fecility: Baltimore, Md. 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. CEREBRAL EDEMA

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last

b. CEREBRAL ARTERIO ANEURYSM

Due to (or es e consequence of):

c. BILATERAL BRONCHOPNEUMONIA

Due to (or es e consequence of):

d. SMALL PULMONARY EMBOLISM

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the ceuse of deeth? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☒Yes 2☐No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☒Yes 2☐No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Ptece of Deeth (Check only one): Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end ptece, end due to the ceuse(s) end menner es steted. 2☐**Medicel Exeminer**: On the basis of exemineticn end/or tnvestigetion, in my opinion, deeth occurred at the time, dete end ptece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Catavenis, M.D.

29c. License number: D30318

29d. Dete signed (Month, Dey, Yeer): JANUARY 9,1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): JAMES CATAVENIS 3001 HOSPITAL DRIVE CHEVERLY MD

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 1997

32. Registrer's Signeture: Julia Gardner-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00312

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MYRTLE I. DURDING

2. Date of Death — Month: JANUARY; Day: 09; Year: 1997

3. Time of Death: 14:15

4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-4542

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 7, 1902

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6116 Dunroming Road

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Henry Long

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Loudenschlager

19a. Informant's Name/Relationship *(Type, Print)*: Isabelle Burrell (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6116 Dunroming Road Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 1-13-97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Fenaman

22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR ACCIDENT — DAYS

Due to (or as a consequence of):

b. HYPERTENSION — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Van Wu M.D

29c. License number: AS2402321-JW-9022

29d. Date signed *(Month, Day, Year)*: JANUARY 09, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOHN VAN WU, M.D. SINAI HOSPITAL OF BALTIMORE, MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Anderson Rendell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Delware

2. Date of Death (Month, Day, Year): January 6, 1997

3. Time of Death: 3:25 p.m.

4a. Facility Name (If not institution, give street and number): Cherrywood Healthcare & Rehabiltation Centre

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-07-6147

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 10, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decadant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 716 Milford Mill Road

10f. Zip Code: 21208

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decadant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 years

College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Private Legal Secretary

16b. Kind of Business/Industry: Law Firm

17. Father's Name (First, Middle, Last): William Harry Prime

18. Mother's Name (First, Middle, Maiden Surname): Sallie G. O'Donnell

19a. Informant's Name/Relationship (Type, Print): Mrs. Carol Dwayer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3208 Acton Road Baltimore, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park

Date: Jan.10,1997

20c. Location - City or Town, State: Sykesville,Maryland

21. Signature of Funeral Service Licensee: John K [illegible]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Progressive dementia, Alzheimer's type

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible]

29c. License number: D27123

29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Judith McKeever 755 Main St. Reisterstown, MD 21136

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia N. Dorsey

2. Date of Death: Month January Day 04 Year 1997

3. Time of Death: 6:04 pm

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-6213

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): July 16, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4700 Alhambra Avenue

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Otis Smith

18. Mother's Name (First, Middle, Maiden Surname): Ethel Butler

19a. Informant's Name/Relationship (Type, Print): Delores Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4700 Alhambra Ave. Balt. MD. 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge

Date: JAN 10, 96

20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Lewis A. Parker

22. Name and Address of Facility: PARKER Funeral Home 3512 Frederick Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximata Intarval Between Onset and Death
Immediate Cause (Final diseasa or condition resulting in death) a.	Sepsis	15 days
Due to (or as a consequence of): b.	Intra abdominal infection	20 days
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of): c.	Bowel Ischemia and Gangren	25days
d.	Cardiac Arrhythmia	26 days

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause givan in Part I.

C.O.P.D Hypertension . Angina

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zabih Habib, MD

29c. License number: AT 2438946

29d. Date signed (Month, Day, Year): January 05 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Zabih Habib, MD 201 E. University Pkwy

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00315

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RANDOLPH R. DULANY
2. Date of Death Month Day Year: JANUARY 04,1997
3. Time of Death: 4:09 PM
4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLENBURNIE
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 215-05-9109
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 19 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1448 Henry Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Worker
16b. Kind of Business/Industry: Federal Govt.

17. Father's Name *(First, Middle, Last)*: George Emory Dulany
18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn Agnes Freeman

19a. Informant's Name/Relationship *(Type, Print)*: Joseph Dulany son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1251 Lorene Drive Pasadena, Md. 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: New Cathedral Cemt.
Date: JAN.08 1997
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: David A. Naylor
22. Name and Address of Facility: McCully Funeral Home of South Balto. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arterio Sclerotic Cardiovascular Dzse

Due to (or as a consequence of):
b. Diabetes Mellitus

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Dimentia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher A Deboja
29c. License number: D42820
29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Deboja 3708 Mountain Rd Pasadena, md 21122

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Judson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00316

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MAE K. ECKELT
2. Dete of Death Month / Dey / Yeer: January 9, 1997
3. Time of Death: 9:05 a.m.
4a. Fecility Neme (If not Institution, give street end number): Bel Forest Nursing Home
4b. City, Town, or Location of Deeth: Forest Hill
4c. County of Deeth: Harford

Funeral Director

5. Social Security Number: 214-01-6987
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): March 31, 1910
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 4206 Silver Spring Road
10f. Zip Code: 21128
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): Unknown / College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Clothing Manufacturing
17. Fether's Neme (First, Middle, Last): Richard Kettlewell
18. Mother's Neme (First, Middle, Meiden Surneme): Catherine Bandel
19e. Informent's Neme/Reletionship (Type, Print): Gerald J. Hock (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2605 Johnson Mill Road, Forest Hill, MD. 21050
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Parkwood Cemetery
Dete: 1/13/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Neme end Address of Fecility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line. (Approximate Interval Between Onset and Death)

Immediete Cause (Finel diseese or condition resulting in deeth): e. diabetes mellitus

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet Initiated events resulting in deeth) Lest

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: colon cancer; bladder cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: ▶ David S. Dunn

29c. License number: D32297

29d. Dete signed (Month, Dey, Yeer): 1/10/97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): DAVID DUNN 615 West MacPhail

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 1997

32. Registrar's Signature: ▶ [signature]

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00317

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris K. Ehlers

2. Date of Death: Month JAN, Day 7, Year 1997

3. Time of Death: 11:55PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Villa Nursing Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-07-9379

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth *(Month, Day, Year)*: MAR 30, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 711 Academy Road

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Organist/Choir Director

16b. Kind of Business/Industry: Church

17. Father's Name *(First, Middle, Last)*: Conrad John Kolb

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Sander

19a. Informant's Name/Relationship *(Type, Print)*: Brian C. Ehlers/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 399 Bungy Rd. N. Scituate, RI 02857

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery | Date: 1/10/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — one day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrick W. White MD

29c. License number: D73365

29d. Date signed *(Month, Day, Year)*: January 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick W. White, 716 Marden Choice Lane #205, Baltimore, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

(5)

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS DOROTHY EDWARDS

2. Date of Death — Month: JAN Day: 05 Year: 1997

3. Time of Death: 9:41 am

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-03-6658

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06-20-15

9. Birthplace (State or Foreign Country): NC.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 5220 York Road Apt. #B

10f. Zip Code: 21204

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 4th Grade — College (1-4 or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aid

16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): William Wilkes

18. Mother's Name (First, Middle, Maiden Surname): Mardecie Wilkes

19a. Informant's Name/Relationship (Type, Print): Carrie Holley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1304 N. Montford Avenue Baltimore, Md. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery — Date: 01-10-97

20c. Location - City or Town, State: Woodlawn, MD.

21. Signature of Funeral Service Licensee: Theresa Irby

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — 30 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) — 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MOHAMED KHARFAN DABAJA, MD

29c. License number: P10589

29d. Date signed (Month, Day, Year): JAN 05 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMED KHARFAN DABAJA 5601 LOCH RAVEN BLV. BALTO, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00319

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES E. ERNEST

2. Date of Death Month / Day / Year: JANUARY 6, 1997

3. Time of Death: 10:26 AM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: Glen BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213 32 4229

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 7, 1935

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8390 Carol Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12th / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Pump Operator

16b. Kind of Business/Industry: Balto. City Fire Dept.

17. Father's Name *(First, Middle, Last)*: John J. Ernest Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary M. Knox

19a. Informant's Name/Relationship *(Type, Print)*: Iris E. Ernest / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8390 Carol Drive Pasadena, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial Pk.

Date: 1/9/97

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Jerome Gronowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43677

29d. Date signed *(Month, Day, Year)*: January 6 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ANDREW DIETZ M.D. 301 HOSPITAL DRIVE. GLEN BURNIE MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

Registrar: L. Baltazar Rondilla

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

30

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00320

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Chester Ebaugh

2. Date of Death Month / Day / Year: January 8, 1997

3. Time of Death: 10:38 a.m.

4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-05-4109

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 18, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3626 Gibbons Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claims Adjustor

16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Albert Ebaugh

18. Mother's Name *(First, Middle, Maiden Surname)*: Effie Cook

19a. Informent's Name/Relationship *(Type, Print)*: Edna Mae Ebaugh (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3626 Gibbons Avenue Baltimore, Md. 21214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery | Date: 1/10/97

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Milton J. Knight Jr

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Anne Owusu MD

29c. License number: P09303

29d. Date signed *(Month, Day, Year)*: JANUARY 9 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANNE OWUSU, GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE MD 21239

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00321

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sharon Kathleen Fletcher

2. Date of Death Month Day Year: Jan. 07, 1997

3. Time of Death: 11:55am

4a. Facility Name *(If not institution, give street and number)*: 900 Maple Hurst Lane

4b. City, Town, or Location of Death: Monkton

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-56-9600

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEP 6, 1950

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decadant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Monkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 900 Maple Hurst Lane

10f. Zip Code: 21111

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Project Manager

16b. Kind of Business/Industry: Payroll Service Co.

17. Father's Name *(First, Middle, Last)*: William J. Fletcher

18. Mother's Name *(First, Middle, Maiden Surname)*: Gloria Clark

19a. Informant's Name/Relationship *(Type, Print)*: William J. Fletcher/Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7923 Springway Road Towson, MD 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. | Date: 1/8/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LIVER METASTASES — 6 months

Due to (or as a consequence of):
b. BREAST CANCER — 2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D37238

29d. Date signed *(Month, Day, Year)*: January 08, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): of John Kennedy MD, Oncology 130, Johns Hopkins Hospital, 600 N Wolfe St

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

(10)

97 00322

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jean Filedora			2. DATE OF DEATH (Month, Day, Year): Jan 06 1997	3. TIME OF DEATH: 10:50 P M
4. SOCIAL SECURITY NUMBER: 545-20-2672	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1916	8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Sykesville Elder Care		9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville		10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7309 2nd Ave		10f. ZIP CODE: 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stenographer	16b. KIND OF BUSINESS/INDUSTRY: U.S.Govt.		
17. FATHER'S NAME (First, Middle, Last): Hillary Harris		18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Powell		
19a. INFORMANT'S NAME (Type/Print): Gail Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 Stoner Ave. Westminster, MD. 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Springfield Cemetery	DATE: 1/9/97	20c. LOCATION — City or Town, State: Sykesville, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian K Haight		22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O.Box 195 Sykesville, MD. 21784		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alzheimers Dementa	5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonia
Septicaphimia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert L. Moon, MD	29c. LICENSE NUMBER: D32882	29d. DATE SIGNED (Month, Day, Year): 1/7/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert L. Moon 714 Business Center Dr.		
31. DATE FILED (Month, Day, Year): JAN 10 1997	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randella	Reisterstown, MD 21136

DHMH 16 Rev 1/89

Q

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN R. FARR SR.
2. Date of Death: Month JAN Day 8 Year 1997
3. Time of Death: 10:26 A.M.
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-18-2772
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 16, 1922
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residance of Dacedent

10e. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1 ☐ Yas 2 X No
10e. Street and Number: 3403 Hazelwood Road
10f. Zip Code: 21037
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Navar Marriad 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yas 2 ☐ No If Yes, Give Yaar or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 5 / College (1-4or 5+):
16a. Decedent's Uaual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Mechanic
16b. Kind of Businass/Industry: Railroad

17. Fathar's Name (First, Middla, Last): Elmer Stallings
18. Mothar's Name (First, Middla, Maidan Surname): Elsie Mae Stallings

19a. Informant's Name/Relationship (Type, Print): Willie Mae Farr - Wife
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 3403 Hazelwood Road, Edgewater, MD 21037

20a. Mathod of Disposition: 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetery, cremetory or othar place): Lakemont Cemetery
Deta: 1/10
20c. Location - City or Town, Stata: Davidsonville, MD

21. Signature of Funeral Service Licansee: ▶ Patrick J. Arundell
22. Nama and Addrass of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications thet caused the daath. Do not entar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one ceusa on aach lina.

Approximate Interval Between Onset and Death

Immedieta Causa (Final diseese or conditlon resulting in daath)
a. METASTATIC BLADDER CANCER 3 YEARS

Dua to (or as a consequance of):

Sequentially list conditions, if any, laeding to immadiate causa. Entar Underlying Cause (Disease or injury that initiated evanta resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yaa 2 X No
24b. Ware autopsy findings available prior to completion of cause of daath? 1 ☐ Yas 2 ☐ No

25. Was casa referred to medical examinar? 1 ☐ Yaa 2 X No

28. Place of Death (Check only ona)
Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Othar: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding investigation 6 ☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 X **Certifying Phyaician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: ▶ Enser W Cole MD
29c. License number: D16354
29d. Date signed (Month, Day, Year): JAN 8 1997

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Enser W. Cole III 900 Bestgate Rd Annapolis, MD 21401

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: ▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00324

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GUENDALINA FOLCARELLI

2. Date of Death Month Day Year: JANUARY 8, 1997

3. Time of Death: 19:20PM

4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216012766

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 5, 1896

9. Birthplace *(State or Foreign Country)*: ITALY

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: WHITE MARSH

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6039 LORELEY BEACH ROAD

10f. Zip Code: 21162

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SEAMTRESS

16b. Kind of Business/Industry: CLOTHING

17. Father's Name *(First, Middle, Last)*: UNK. PETRILLI

18. Mother's Name *(First, Middle, Maiden Surname)*: UNK. UNK.

19a. Informent's Name/Relationship *(Type, Print)*: AMERICO FOLCARELLI/ SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6039 LORELEY BEACH ROAD, WHITE MARSH, MD 21162

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HOLY REDEEMER

Date: 1/11/97

20c. Location - City or Town, State: BALTIMORE MD

21. Signature of Funeral Service Licensee: Denis J. Kelly

22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia — one day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrick W. White M.D.

29c. License number: D23365

29d. Date signed *(Month, Day, Year)*: January 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. PATRICK WHITE 900 S. CATON AVENUE BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Linda Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00325

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gloria T Fisher
2. Date of Death Month: Jan Day: 4 Year: 1997
3. Time of Death: 12:11 PM
4a. Facility Name *(If not institution, give street and number)*: Union Memorial
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-26-8095
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 67 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09/01/1929
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1501 E. 35th Street
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th / College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bar Maid
16b. Kind of Business/Industry: Bar

17. Father's Name *(First, Middle, Last)*: William Arthur
18. Mother's Name *(First, Middle, Maiden Surname)*: Lylie Arthur

19a. Informant's Name/Relationship *(Type, Print)*: LaTanya Fulton/Daugther
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1501 E. 35th Street, Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial Park
Date: 1/8/97
20c. Location - City or Town, State: Woodlawn, Md.

21. Signature of Funeral Service Licensee: Tami G. Close
22. Name and Address of Facility: William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac arrythmia — 1 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: seizure disorder, pancreatic insufficiency, hypertension, esophageal cancer

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fred Hsieh MD
29c. License number: N3195
29d. Date signed *(Month, Day, Year)*: Jan 7 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Fred Hsieh Tower 110 Johns Hopkins Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Li Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00326

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ferdinand F. Farrell

2. Date of Death: Month January Day 05 Year 1997

3. Time of Death: 01:30am

4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-7265

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 28, 1908

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 979 REGINA DRIVE

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR

16b. Kind of Business/Industry: MONTGOMERY WARDS

17. Father's Name (First, Middle, Last): JOHN FARRELL

18. Mother's Name (First, Middle, Maiden Surname): KATHERINE DeBOY

19a. Informant's Name/Relationship (Type, Print): PATRICK J. FARRELL (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 WYNNEWOOD COURT - BALTIMORE, MD 21227

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): NEW CATHEDERAL CEMETERY

Date: 1/7/97

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Jackie D. Shannon

22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction — 30 minutes

Due to (or as a consequence of):

b. Coronary artery disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kevin M. Scanlon MD

29c. License number: D38543

29d. Date signed (Month, Day, Year): January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin M. Scanlon MD 900 Caton Avenue Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Madison Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Theresa GETEK
2. Date of Death (Month, Day, Year): January 7, 1997
3. Time of Death: 10:55 Pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-6647
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1919
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3831 Joppa Road, Apt. 3B
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Tailoring Co.

17. Father's Name (First, Middle, Last): Joseph Schab
18. Mother's Name (First, Middle, Maiden Surname): Julia (Surname Unknown)

19a. Informant's Name/Relationship (Type, Print): Richard V. Getek (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Berrycrest Ct., Cockeysville, MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Stanislaus Cemetery
Date: 1/11/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death) e. Cerebrovascular accident — 5 days

Due to (or as e consequence ot): Hypertension — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Due to (or as a consequence ot):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic atrial fibrillation

23b. Did tobacco uea contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evallable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner ot Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best ot my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner as stated. 2☐ **Medical Examinar**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D47746
29d. Dete signed (Month, Day, Year): 1/7/97

30. Name and address ot person who completed cause of death (Item 23e) (Type, Print): Thomas Burke MD 9000 Franklin Square Hospital Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Dey, Year): JAN 10 1997
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00328

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MIRIAM	C.	GUARINO	JANUARY	06	1997	3:15 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SAINT JOSEPH MEDICAL CENTER	TOWSON, MARYLAND	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-24-5373	1☐ M 2☒ F	68 Yrs.					DEC. 19, 1928	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD	ABINGDON	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2805 GRAY ANTLER COURT	21009	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8TH GRADE		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HARVEY JETT	PEARL HAYNIE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANNETTE FURLONG (DAUGHTER)	2805 GRAY ANTLER COURT, ABINGDON, MD. 21009

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GREEN MOUNT CREMATORY	1/8/97	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SCHIMUNEK FUNERAL HOME OF BEL AIR, INC. 610 W. MAC PHAIL ROAD, BEL AIR, MD. 21014

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GASTROINTESTINAL BLEEDING	30 MIN
Due to (or as a consequence of):	CONGESTIVE HEART FAILURE	1 HOUR
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): RESPIRATORY FAILURE	1 HOUR
	c. Due to (or as a consequence of): CORONARY ARTERY DISEASE	1 MONTH
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Mark G Midei	D30042	1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARK MIDEI, M.D. 6569 N. CHARLES STREET, BALTIMORE, MARYLAND 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 1997	▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00329

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: GILDA M GROSS

2. Dete of Deeth Month / Dey / Yeer: JANUARY 4, 1997

3. Time of Death: 9:50PM

4e. Fecility Neme *(If not institution, give street end number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Deeth: BALTIMORE CITY

4c. County of Deeth: NA

Funeral Director

5. Sociel Security Number: 217-80-9753

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 36 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 02-06-60

9. Birthplace *(State or Foreign Country)*: MD

Usuel Residence of Decedent

10e. Stete: MD.

10b. County: NA

10c. Clty, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 100 N. Decker Street

10f. Zip Code: 21224

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*

Elementery/Secondary (0-12): 11th Grade

College (1-4or 5+): Na

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ChildCare

16b. Kind of Business/Industry: Unemployed

17. Fether's Neme *(First, Middle, Last)*: Lawrence Gross Sr.

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Marceleine Wilkins

19e. Informent's Neme/Reletionship *(Type, Print)*: Marceleine McCoy

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8 Bitteroof Court Apt. D Owings Mills, Md. 21117

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other pleca)*: Baltimore Cem.

Dete: 01-10-97

20c. Location - City or Town, Stete: Baltimore, MD.

21. Signeture of Funerel Service Licensee: Susan Hhagen

22. Neme end Address of Feciliity: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): e. PULMONARY ASPERGILLOSIS — ONE MONTH

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest:

b. ACUTE RENAL FAILURE — TWO WEEKS

Due to (or es e consequence of):

c. RETROVIRAL INFECTION — FIVE YEARS

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Steven Dudek MD

29c. License number: RES-000

29d. Dete signed *(Month, Dey, Yeer)*: JANUARY 4, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): STEVEN DUDEK, MD. THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21287

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 10 1997

32. Registrer's Signeture: Julie Davidson Parker

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Please Type Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00330

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL F. GLOS, SR.
2. Date of Death: Month JANUARY Day 8, Year 1997
3. Time of Death: 10:50 A.M.
4a. Facility Name *(If not institution, give street and number)*: MANOR CARE NURSING HOME
4b. City, Town, or Location of Death: ROSSVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-07-9153
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCTOBER 2, 1919
9. Birthplace *(State or Foreign Country)*: BALTIMORE CITY, MD.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE COUNTY
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7521 BELAIR ROAD
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: WATCH REPAIRMAN
16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name *(First, Middle, Last)*: MICHAEL F. GLOS
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY HOHMAN

19a. Informant's Name/Relationship *(Type, Print)*: MARY E. GLOS (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7521 BELAIR ROAD BALTIMORE, MARYLAND 21236

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOST HOLY REDEEMER CEMETERY — Date: JANUARY 11, 1997
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Heather Lassahn
22. Name and Address of Facility: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute renal failure	weeks
Due to (or as a consequence of): b.	Chronic renal failure	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCVD, CVA, IDDM, Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard S Freeland MD
29c. License number: D28127
29d. Date signed *(Month, Day, Year)*: 1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard S Freeland MD 5601 Loch Raven Blvd Balto MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00331

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Adel Gimpel

2. Date of Death Month Day Year: January 8, 1997

3. Time of Death: 2000

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 182-01-8933

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 4 1896

9. Birthplace *(State or Foreign Country)*: Hungary

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: West Friendship

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2598 Wellworth Way

10f. Zip Code: 21794

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Clothing Factory

17. Father's Name *(First, Middle, Last)*: Nicholas Reis

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Reis

19a. Informant's Name/Relationship *(Type, Print)*: Charlene Misener (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2598 Wellworth Way W. Friendship MD 21794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Lake View Mem. Park | Date: 1/11/97

20c. Location - City or Town, State: Sykesville MD

21. Signature of Funeral Service Licensee: Brian P. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onsat and Death
Immediate Ceuse (Final disaasa or condition resulting in death) a.	Pneumonia, RIGHT LUNG	3 days
Due to (or as a consequence of): b.	Congestive Heart Failure	10 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other signifiicent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☒ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Exeminar:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrick A Turners

29c. License number: D20806

29d. Date signed *(Month, Dey, Year)*: 1/9/97

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): PATRICK A TURNER 1425 Liberty Road Eldersburg, MD 21784

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97-0072-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00332

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY Susie HUDSON
2. Date of Death Month Day Year: JAN. 5, 1997
3. Time of Death: 1:15 AM
4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL E.R.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-40-5671
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 1, 1909
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3904 West Cold Spring Lane
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 6th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Cafeteria Employee
16b. Kind of Business/Industry: Balto City School Syst

17. Fether's Name *(First, Middle, Last)*: James H. Ball
18. Mother's Name *(First, Middle, Maiden Surname)*: Sue Emma Williams

19a. Informant's Name/Relationship *(Type, Print)*: niece Alma E. Norris
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: PSC7 Box 437 APO AE 09104

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Memorial Park
Date: Jan 11
20c. Location - City or Town, State: Baltimore County, MD

21. Signature of Funeral Servica Licensee: ▶ Barry L. Rollins
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yas 2☐ No

28. Piece of Deeth *(Check only one)*: Hospital: 1☐ inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Margarita Korell
29c. License number: O.C.M.E
29d. Date aigned *(Month, Day, Year)*: JAN. 5, 1997

30. Name and address of parson who completed cause ot death (Item 23e) (Typa, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 1 0 1997
32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Print. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Archie Harrison

2. Date of Death: Month Jan. Day 7, Year 1997

3. Time of Death: 5:45am

4a. Facility Name (If not institution, give street and number): Irvington Knoll Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-28-7355

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 08-19-32

9. Birthpiace (Stete or Foreign Country): VA

Usual Residance of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2 ☐ No

10e. Street and Number: 2741 Round Road

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Raca - Amarican Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: NA

17. Father's Name (First, Middle, Lest): Unknown

18. Mother's Name (First, Middle, Maiden Surneme): Vernice Morgan

19a. Informant's Name/Relationship (Type, Print): Aretta Dunham

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1709 Benvene Forest Road Rockymount, NC 27804

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other pleca): Voshell Mem. Garden

Date: 01-11-97

20c. Location - City or Town, Stata: Dundalk, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Addrass of Facility: March F.H. East 1101 E. North Ave.

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failiure. List only one cause on each line.

		Approximata Interval Between Onsei and Death
Immediate Cause (Finai disaasa or condition resulting in death) e.	Coronary Arlery disease	years
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last b.	Cerebrovascular Accident	years
Due to (or as a consequence of):		
c.	Atherosclerosis	Years
Due to (or as a consaquenca of):		
d.	Peptic ulcer disease	-

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Naturei 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office buiiding, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. Licanse number: D41497

29d. Data signed (Month, Day, Year): 1/8/97

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): 405 Stemmers Run Road Baltimor MD 2122/

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Joseph Holt

2. Date of Death: Month: January; Day: 8; Year: 1997

3. Time of Death: 5:25 AM

4a. Facility Name (If not institution, give street and number): Ivy Hall Geriatric Center

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-18-4434

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): April 5, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8620 Kelso Drive Apt. 216 A

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BGE Meter Reader

16b. Kind of Business/Industry: Utility Co.

17. Father's Name (First, Middle, Last): Norman Holt

18. Mother's Name (First, Middle, Maiden Surname): Margaret Kennedy

19a. Informant's Name/Relationship (Type, Print): Robert N. Holt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 313 Honomv Hawai 76728

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gardens

Date: 1/11/1997

20c. Location - City or Town, State: Baltimore, Co. , Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer — one year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bashar Karakash M.D.

29c. License number: D47813

29d. Date signed (Month, Day, Year): January 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BASHAR KARAKASH 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00335

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Helen Haynie

2. Date of Death — Month: January; Day: 7; Year: 1997

3. Time of Death: 5:45 A.M.

4a. Facility Name *(If not institution, give street and number)*: Chesapeake Manor Extended Care

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217 01 8445

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 3, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 238 Carvel Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12); Collega (1-4or 5+): 2 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Simon Povilaitis

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Kurapka

19a. Informent's Name/Ralationship *(Type, Print)*: Robert M. Haynie / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 238 Carvel Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 1/10/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zgamiowski

22. Name end Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. Only ona cause on aach line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseasa or condition resulting in death) a.	Pneumonia	1 week
Due to (or as a consequence of): b.	Aspiration	2 week
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest — Due to (or as a consequence of): c.	Cerebrovascular Accident	1 Year
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, date and placa, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of cartifier: C Wymer MD Attending Doctor

29c. License number: D 21684

29d. Date signed *(Month, Day, Year)*: 1/8/97

30. Nama and address of person who complated cause of daath (Item 23a) (Type, Print): C.V. CYRIAC MD 8105 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signatura: Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trauma event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Verdie Blanche Hirt
2. Date of Death Month Day Year: Jan 8, 1997
3. Time of Death: 9:03 A.M.
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-22-2274
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 24, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7004 Windsor Mill Road
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Raymond Neeb
18. Mother's Name (First, Middle, Maiden Surname): Blanche Vertie Sutch

19a. Informant's Name/Relationship (Type, Print): Mr. John Hirt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7004 Windsor Mill Road Baltimore, MD 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 1/11/97
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: ▶ Stephen M Jenkins
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage Renal Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ T. Kawaja
29c. License number: D25112
29d. Date signed (Month, Day, Year): January 8 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TAHOORA KAWAJA 5310 Old Court Rd Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julia Davison-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 4c, per F.H. G-743 1/10/97 reb

Certificate of Death

Reg. No. 97 00337

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph William Hodiste

2. Date of Death Month: JANUARY Day: 8 Year: 1997

3. Time of Death: 6 00 pm

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: ~~Baltimore City~~ N/A

Funeral Director

5. Social Security Number: 214-40-8935

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 3, 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 1128 W. 43rd Street

10f. Zip Code: 21211

10g. Citizen of What Country: USA

11. Marital Status: 1 Never Married XX 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Compounder/Processing Tech.

16b. Kind of Business/Industry: Noxell Inc.

17. Father's Name (First, Middle, Last): William H. Hodiste

18. Mother's Name (First, Middle, Maiden Surname): Ida Thompson

19a. Informant's Name/Relationship (Type, Print): Sandra J. Hodiste (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1128 W. 43rd Street Baltimore, Maryland 21211

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park Cemetery

Date: 1/13/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Burgee-Henss Carpenter

22. Name and Address of Facility: Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Failure	minutes
Due to (or as a consequence of):		
b.	carcinomatosis Meningitis	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
Due to (or as a consequence of):		
c.	metastatic lung cancer	22 months
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably X 4 Unknown

24a. Was an autopsy performed? 1 Yes XX 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes X 2 No

26. Place of Death (Check only one)

Hospital: X 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): X 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D44944

29d. Date signed (Month, Day, Year): 1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STANLEY WALLER Union Memorial Hospital Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00338

Item: 4c, per F.H. G-743 1/10/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth L. Holloway

2. Date of Death: Month January, Day 7, Year 1997

3. Time of Death: 440P

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A ~~Baltimore City~~

Funeral Director

5. Social Security Number: 220-20-5617

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March29,1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4319 Newport Avenue

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Howard Sellers

18. Mother's Name (First, Middle, Maiden Surname): Julia W. Dell

19a. Informent's Name/Reletionship (Type, Print): John L. Holloway

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8391 Morven Road, Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of Cemetery, crematory, or other place): Hilltop Service Corp

Date: 1/9

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Lynn Burgee Henss

22. Name and Address of Facility: Burgee-Henss Funeral Home 21211, 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastic Malignant Neoplasm of Kidney

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tarun Mullik

29c. License number: TM-9018

29d. Date signed (Month, Day, Year): January 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tarun Mullick, Sinai Hospital 2401 West Belvedere Avenue

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrer's Signature: Jacqueline Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL HILL

2. Date of Death: Month JANUARY Day 04 Year 1997

3. Time of Death: 12:00 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 577-24-7231

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 1, 1922

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4601 Pall Mall Rd.

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plunger

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Michelle Hunter / social worker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4601 Pall Mall Rd. Baltimore, MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: 1/7

20c. Location - City or Town, State: Landsdowne, MD

21. Signature of Funeral Service Licensee: Kevin Parker

22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ENTEROCOCCAL SEPSIS

Due to (or as a consequence of): b. LEG GANGRENE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. HEART FAILURE

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GASTRIC TUBE PLACEMENT

STROKE WITH RESULTING DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mircea Todor, MD

29c. License number: AS2402321-MT9004

29d. Date signed (Month, Day, Year): JANUARY 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIRCEA TODOR 2401 WEST BELVEDERE AVE., SINAI HOSPITAL OF BALTIMORE, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00340

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Antoinette Cecelia Howser
2. Date of Death Month: Jan Day: 7 Year: 1997
3. Time of Death: 6:00pm
4a. Facility Name *(If not institution, give street and number)*: 928 Pierpoint Dr.
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-10-5607
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 30 1914
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 928 Pierpoint Drive
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: seamstress
16b. Kind of Business/Industry: Tailor Hass Co.

17. Father's Name *(First, Middle, Last)*: George Cuczula
18. Mother's Name *(First, Middle, Maiden Surname)*: Annasi Zarraccota

19a. Informant's Name/Relationship *(Type, Print)*: William Howser/nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 505 Sylview Drive Pasadena, Md. 21122

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc. — Date: JAN.09 1997
20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: Eugene J Lentz Jr
22. Name and Address of Facility: McCully Funeral Home of Pasadena 3204 Mountain Road Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. asphyxiation — Due to (or as a consequence of): — 60 min.

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☑ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: Jan 7 1997
28b. Time of Injury: Unknown M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: suicide by hanging
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 928 Pierpoint Dr. Pasadena

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jeffrey Buggins
29c. License number: D28640
29d. Date signed *(Month, Day, Year)*: Jan 7, 1997
30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: 2011 Sentry Circle apt 102 Odenton, Md 21113

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Mason-Kendall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DIETRICH E. HAGEDORN

2. Date of Death: Month JANUARY Day 4 Year 1997

3. Time of Death: 0145 AM

4a. Facility Name (If not Institution, give street and number): NORTH ARUNDEL HOSPITAL 301 HOSPITAL DRIVE

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 144-09-3254

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 22, 1907

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 7126 Springhouse Lane

10f. Zip Code: 21226

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Designer

16b. Kind of Business/Industry: Textile Industry

17. Father's Name (First, Middle, Last): Emile Hagedorn

18. Mother's Name (First, Middle, Maiden Surname): Agnes Wahrendorf

19a. Informant's Name/Relationship (Type, Print): Mrs. Dorothy M. Hagedorn/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7126 Springhouse Lane Baltimore, Md. 21226

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory Date: 1/6/97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Eugene J. Carton Jr.

22. Name and Address of Facility: McCully Funeral Home of Pasadena 3204 Mountain Road Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. GASTRO INTESTINAL BLEEDING

Due to (or as a consequence of):

c. DEHYDRATION

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check one only)

Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN

29c. License number: D49145

29d. Date signed (Month, Day, Year): JANUARY 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ONARAJO BOLAJI 301 HOSPITAL DRIVE

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-0044-510
CIP ITEM: 16a, PER F.H. FILM G-743
1/10/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
MILLARD	GEORGE	JEFFERIES	JANUARY 2, 1997	10:50AM

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
404 ANNABELLE AVENUE	BALTIMORE	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-14-4100	1☒M 2☐F	81 Yrs.			OCT.11 1915	Balto.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
404 Annabelle Ave.	21225	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	Sheetmetal ~~worker~~ WORKER	Miller Metal Prods.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John W. Jefferies	Clara M. Schline

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vera M. Costa/Sister	409 Doris Ave. Baltimore, Md. 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory, Inc.	JAN.04 1997	Catonsville, Md.

21. Signature of Funeral Service Licensee: ▶ Daniel A. Taylor

22. Name and Address of Facility: McCully Funeral Home of Brooklyn 237 Patapsco Ave. Balto. Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
INSPECTED 1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	27. Manner of Death
☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)	☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chute MD	O.C.M.E.	JANUARY 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ITEMS: 17. & 18. PER F.H.
FILM g-743 1/10/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence A. Jones

2. Date of Death Month: January Day: 5 Year: 97

3. Time of Death: 9:20 P.M.

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 400-34-9816

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 30, 1923

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1101 Washington Blvd.

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Cemetery

17. Father's Name (First, Middle, Last): ~~unknown~~ HENRY Jones

18. Mother's Name (First, Middle, Maiden Surname): LELA EDNA unknown

19a. Informant's Name/Relationship (Type, Print): Eva I Jones/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1101 Washington Blvd. Balto., Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Glen Haven Mem. Pk. Date: 1/9/97

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: David A Hayes

22. Name and Address of Facility: McCully Funeral Home of South Balto. 130 E. Fort Ave. Balto., Md. 21230

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest — 6 days

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kenneth Gin MD

29c. License number: D48089

29d. Date signed (Month, Day, Year): 1/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mercy Medical Center, Baltimore, MD 21202

1/5

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00344

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPHINE KURPISZ
2. Date of Death Month / Day / Year: JAN. 3rd, 1997
3. Time of Death: 6:00 P.M.
4a. Facility Name *(If not institution, give street and number)*: Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-0351
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 104 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 15, 1892
9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4361 Seidel Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: Poland

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): N/A — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Adalbert Marek
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Gierett
19a. Informant's Name/Relationship *(Type, Print)*: Isabelle Garrity (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4220 Sheldon Avenue, Baltimore, Maryland 21206
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Cross Polish Nat'l Cem. — Date: 1-7
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. URINARY TRACT SEPSIS — DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEHYDRATION; RENAL FAILURE; SENILITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)* — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. P. Nazemi MD
29c. License number: D17322
29d. Date signed *(Month, Day, Year)*: JAN. 3rd, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): A. P. NAZEMI, M.D. CHURCH HOSPITAL, BALTO MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clare Dorothy Krein
2. Date of Death (Month, Day, Year): January 8, 1997
3. Time of Death: 8:44 PM
4a. Facility Name (If not institution, give street and number): Dulaney-Towson Health Care Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-5446
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 25, 1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3002 Rueckert Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hairdresser
16b. Kind of Business/Industry: Beauty Shop

17. Father's Name (First, Middle, Last): Stanley Holowinski
18. Mother's Name (First, Middle, Maiden Surname): Catherine Rataczak

19a. Informant's Name/Relationship (Type, Print): Joann C. Cullen (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Ruxview Court (Apt. 301), Baltimore, MD 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cemetery
Date: 1-8-97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction
Due to (or as a consequence of):
b. AS CVD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D07697
29d. Date signed (Month, Day, Year): 1/10/98

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Marcio M. Menendez M.D Suite 408 7505 Oster Dr Towson, md 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfred J. Kowalewski
2. Date of Death (Month, Day, Year): January 9, 1997
3. Time of Death: 4:00 AM
4e. Facility Name (If not institution, give street and number): 3703 Ravenwood Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-12-0691
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 16, 1924
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3703 Ravenwood Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bricklayer
16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Francis J. Kowalewski
18. Mother's Name (First, Middle, Maiden Surname): Rose Yurek

19a. Informant's Name/Relationship (Type, Print): David Kowalewski (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Delight Avenue, Baltimore, Maryland 21236

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 1-11
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]
22. Name and Address of Facility: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. metastatic lung cancer	3 months
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] M.D.
29c. License number: D44944
29d. Date signed (Month, Day, Year): 1/10/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stan Walter Union Memorial Hospital Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kartar Kaur

2. Date of Death: Month Jan, Day 06, Year 1997

3. Time of Death: 5:00pm

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-11-7066

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1926

9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13401 Triadelphia Road

10f. Zip Code: 21042

10g. Citizen of What Country? British

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Wife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Channan Singh Sembhi

18. Mother's Name (First, Middle, Maiden Surname): Pali Kaur

19a. Informant's Name/Relationship (Type, Print): Nirmal Singh Saund/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13401 Triadelphia Rd. Ellicott City, MD 21042

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 1/9/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ischemic Cardiomyopathy — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael [signature] MD

29c. License number: D41274

29d. Date signed (Month, Day, Year): Jan 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Silverman MD 11085 Little Patuxent Pkwy Columbia, MD 21044

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00348

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arelette Alverta Kesler

2. Date of Death Month: JANUARY Day: 3 Year: 1997

3. Time of Death: 11:30 AM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-76-8516

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 25 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-23-71

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residance of Decadant

10a. State: MD.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1811 Dalhouse Court Apt.#B-1

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondery (0-12): 12th Grade

College (1-4or 5+): Na

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Assistance

16b. Kind of Business/Industry: Dept. Md. State Health

17. Father's Name *(First, Middle, Last)*: Albert W. Lawson

18. Mother's Name *(First, Middle, Maiden Surname)*: Alverta Coleman

19a. Informant's Name/Relationship *(Type, Print)*: William Kesler

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1811 Dalhouse Court Apt.#B-1 Balto.,MD. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Cem.

Date: 01-10-97

20c. Location - City or Town, State: Cockeysville, Md.

21. Signature of Funeral Service Licensee: Valorie A. Davis

22. Name and Address of Facility: Baltimore, Md. 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE PULMONARY EMBOLISM — 3 WEEKS

Due to (or as a consequence of):

b. UTERINE + OVARIAN VEINS THROMBOSIS — 3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. STATUS POST PREGNANCY — MONTHS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carlos M. Orbegoso M.D.

29c. License number: D15354

29d. Date signed *(Month, Day, Year)*: JANUARY, 4TH. 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARLOS M. ORBEGOSO M.D. 201 E. UNIV. PKWY - BALTO. 21218

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00349

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edna M. Kirk

2. Date of Death Month Day Year: January 5, 1997

3. Time of Death: 6:35AM

4a. Facility Name *(If not institution, give street and number)*: Ivy Hall Geriatric Center

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 224 16 8353

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 18, 1915

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decadent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 22 Walkway Court

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Bus Matron

16b. Kind of Business/Industry: Balto. County

17. Father's Name *(First, Middle, Last)*: Robert Taylor

18. Mother's Name *(First, Middle, Maiden Surname)*: Daisey (unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Joyce Bertrand (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 208 apt 1b Middleway Road Middle River, Maryland 21220

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens

Date: 1/7/1997

20c. Location - City or Town, State: Baltimore Co., Maryland

21. Signature of Funeral Service Licensee: James Bruzdzinski

22. Name and Address of Facility: Bruzdzinski Funeral Home PA
1407 Old Eastern Ave. Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. -Sarcomatosis, abdomen & pelvis — 6 mos

Due to (or as a consequence of):
b. -Sarcoma of the uterus — 9 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Miguel A. Castro Jr. MD

29c. License number: DO 1021

29d. Date signed *(Month, Day, Year)*: 1/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIGUEL A. CASTRO, JR., MD
805 FUSELAGE AVE
BALTIMORE, MD. 21220

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00350

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY KEAVNEY
2. Date of Death (Month, Day, Year): January 7, 1997
3. Time of Death: 8:00 A.M.
4a. Facility Name (If not institution, give street and number): Stella MAris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-6594
6. Sex: 1☐ M 2☐ F XXX
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 24, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No XXXX
10e. Street and Number: 439 Old Trail
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married XXX 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XXX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Advertising

17. Father's Name (First, Middle, Last): Thomas Vincent Tumbleson
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Hogan

19a. Informant's Name/Relationship (Type, Print): Robert J. Muth Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 439 Old Trail Baltimore, Maryland 21212

20a. Method of Disposition: XXX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Dulaney Valley Mem Gar
Date: 1/10/97
20c. Location - City or Town, State: Lutherville, Maryland

21. Signature of Funeral Service Licensee: Bruce Stephen Kenek
22. Name and Address of Facility: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Idiopathic Progressive Multifocal Leukoencephalopathy — 3 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kendall Faulkner
29c. License number: D25643
29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00351

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DORIS EDITH KUJAWA

2. Date of Death Month Day Year: January 9, 1997

3. Time of Death: 9:15AM

4e. Facility Name *(If not institution, give street and number)*: 6009 Carter Avenue

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-12-8350

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 13,1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6009 Carter Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 yr's; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Operator

16b. Kind of Business/Industry: Telephone

17. Father's Name *(First, Middle, Last)*: Mordecai R. Ewing

18. Mother's Name *(First, Middle, Maiden Surneme)*: Delevia Hackett

19e. Informant's Name/Reletionship *(Type, Print)*: Mr. Valentine Kujawa - Husband

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6009 Carter Avenue Baltimore,MD 21214

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☒ Other *(Specify)* Entombment

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery

Date: 1/13/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Milton J. Knight

22. Name end Address of Facility: Baltimore,Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. LIVER Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ ~~No~~ 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ ~~No~~

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☐ ~~No~~

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ ~~Residence~~ 6☐ Other *(Specify)*

27. Manner of Death: 1☐ ~~Natural~~ 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Yeer)*: N/A

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*: N/A

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete and piace, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Mari Blackburn.

29c. License number: MD H45300

29d. Dete signed *(Month, Day, Year)*: 1/9/97

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Mari Blackburn, M.D. 9512 Harford Rd.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00352

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Roediger Kaiss, Jr.

2. Date of Death — Month: 01 Day: 07 Year: 1997

3. Time of Death: 3:00 AM

4a. Facility Name *(If not institution, give street and number)*: 6823 Fairdel Avenue

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: ----------

Funeral Director

5. Social Security Number: 219-36-1560

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 26, 1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: ----------

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6823 Fairdel Avenue

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claims Adjuster

16b. Kind of Business/Industry: State Of Maryland

17. Father's Name *(First, Middle, Last)*: George Roediger Kaiss, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Appel

19a. Informant's Name/Relationship *(Type, Print)*: Kenneth B. Kaiss

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 37 Green Leaf Rd. Baltimore, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 1/11/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: John J. Dippel Jr

22. Name and Address of Facility: Dippel Funeral Home, Inc. 7110 Belair Rd. Baltimore, MD. 21206

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: 016066

29d. Date signed *(Month, Day, Year)*: 1/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Lakkoumis 7505 Osler Dr. Towson MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00353

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLEO LAVETA COPP LAMBERT

2. Date of Death Month Day Year: January 4, 1997

3. Time of Death: 10:05AM

4a. Facility Name *(If not institution, give street and number)*: 2705 Glen Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-8174

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 09, 1922

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2705 Glen Avenue

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* USA

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 yrs; College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaking

16b. Kind of Business/Industry: Own Residence

17. Father's Name *(First, Middle, Last)*: William G. Copp

18. Mother's Name *(First, Middle, Maiden Surname)*: Madeline L. High

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Vicki R. Hagin (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24 Castle Hill Court, Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery

Date: 1/7/97

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Home
6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA — 4-5 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ✓ Martin D. Lawson, M.D.

29c. License number: D 42561

29d. Date signed *(Month, Day, Year)*: ✓ 1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin I. Passen, M.D. 1501 Sulgrave Avenue, Baltimore, Maryland 21209

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: John Davidson Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00354

Item: 8, per F.H.G-743 1/16/97 reb = *Certificate of Death* Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
HERBERT	C.	LIPPY	JANUARY	8,	1997	9:08 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SAINT JOSEPH MEDICAL CENTER	TOWSON, MARYLAND	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-05-3926	XX 1☐ M 2☐ F	86 Yrs.					Nov. 9, ~~1010~~ 1910	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Lutherville	1☐ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11504 Greenspring Avenue	21093	USA

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced	XX Yes 2☐ No If Yes, Give Year or Dates: WWII	1☐ Yes 2X No *Specify:*	*Specify:* white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Meter Reader	Baltimore Gas & Electric

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Weber Guy Lippy	Myrtle Dodrer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bessie C. Lippy (Wife)	11504 Greenspring Avenue Lutherville, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1X Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Moreland Memorial Park	1/11/97	Parkville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline Carpenter	Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	4 WEEKS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes X 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes X 2☐ No	1☐ Yes X 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes X 2☐ No	Hospital: X 1 Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Brian J Bohner	D 43489	1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BRIAN J. BOHNER, M.D. 6569 NORTH CHARLES STREET, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 1997	▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna M. Lyon

2. Date of Death (Month, Day, Year): 01 05 97

3. Time of Death: 2:55PM

4a. Facility Name (If not institution, give street and number): Maryland Masonic Homes 300 International Circle

4b. City, Town, or Location of Death: Cockeysville, MD.

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-10-3818

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 27, 1902

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☐ No — X

10e. Street and Number: 300 International Circle

10f. Zip Code: 21030

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): John Joseph Male

18. Mother's Name (First, Middle, Maiden Surname): Theresa A. Dempsey

19a. Informant's Name/Relationship (Type, Print): Franklin A. Miles

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 430 Devon Road, Camp Hill, Pennsylvania 17011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Woodlawn Cemetery

Date: 01/11

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Lynn Burgee Henss

22. Name and Address of Facility: Burgee-Henss Funeral Home 21211, 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. myocardial infarction — acute

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Breiner MD

29c. License number: D40208

29d. Date signed (Month, Day, Year): 1/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): June Breiner 1205 York Rd Ste 32C Lutherville Md 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00356

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY JOSEPH LUERS

2. Date of Death Month Day Year: JAN. 9, 1997

3. Time of Death: 5:15 AM

4a. Facility Name (If not institution, give street and number): 1771 AMUSKAI ROAD

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-03-3728

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/2/09

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1771 AMUSKAI ROAD

10f. Zip Code: 21234

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): QUALITY CONTROL

16b. Kind of Business/Industry: AAI

17. Father's Name (First, Middle, Last): HERMAN LUERS

18. Mother's Name (First, Middle, Maiden Surname): ELLEN HEMLER

19a. Informant's Name/Relationship (Type, Print): FRANCES B. LUERS WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1771 AMUSKAI ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETRY | Date: 1/13/97

20c. Location - City or Town, State: PIKESVILLE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SMALL CELL CARCINOMA OF LUNG — 2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D31189

29d. Date signed (Month, Day, Year): JAN. 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. J. ANINSOHN, MD 888 WILLOW WOODS RD, BALTIMORE, MD 21234

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM J. MARTINEZ
2. Date of Death — Month: JAN Day: 4 Year: '97
3. Time of Death: 10.40Pm
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 190-36-4433
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 23, 1949
9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5491 Marsh Hawk Way
10f. Zip Code: 21045
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Independent Contractor
16b. Kind of Business/Industry: Home Improvements

17. Father's Name (First, Middle, Last): Frank A. Martinez
18. Mother's Name (First, Middle, Maiden Surname): Jane Devinney

19a. Informant's Name/Relationship (Type, Print): Margaret A. Martinez / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5491 Marsh Hawk Way Columbia, Maryland 21045

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Columbia Memorial Park
Date: 1/10/97
20c. Location - City or Town, State: Columbia, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MANTLE CELL LYMPHOMA — 2 yrs

Due to (or as a consequence of):
b. GRAFT VS HOST DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. BONE MARROW TRANSPLANT

Due to (or as a consequence of):
d. THROMBOCYTOPENIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Clement Knight
29c. License number: 24139
29d. Date signed (Month, Day, Year): JAN, 5, '97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard Cty Gen. Hospital Clement Knight, M.D.

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

(15)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00358

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JEANNETTE MOORE
2. Date of Death Month: January Day: 6, Year: 1997
3. Time of Death: 1:50AM
4a. Facility Name *(If not Institution, give street and number)*: GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: 19

Funeral Director

5. Social Security Number: 215-30-2271
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-08-29
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1225 Silverthorne Road
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Private Duty

17. Father's Name *(First, Middle, Last)*: Kermit Hayes
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Sisco

19a. Informent's Name/Relationship *(Type, Print)*: Lawrence JOhnson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4028 Echodale Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Mem. PK. CEM.
Date: 01-10-97
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Teresa L. Chaney
22. Name and Address of Facility: WM. C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	≈2 weeks
Due to (or as a consequence of): b.	CEREBRAL INFARCTION	≈2-3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	SEIZURE	years
Due to (or as a consequence of): d.	MENINGITIS	≈1 week

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Igor Voronetsky, MD
29c. License number: P 10578
29d. Date signed *(Month, Day, Year)*: JANUARY 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IGOR VORONETSKY — GOOD SAMARITAN HOSPITAL

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN LEO MUELLER , III

2. Date of Death Month Day Year: JANUARY 09, 1997

3. Time of Death: 12:32 P.M.

4a. Facility Name (If not institution, give street and number): 10318 GELDING DRIVE

4b. City, Town, or Location of Death: COCKEYSVILLE

4c. County of Death: BALTIMORE COUNTY

Funeral Director

5. Social Security Number: 218-40-8599

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN.16,1943

9. Birthplace (State or Foreign Country): BALTIMORE CITY

Usual Residance of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: COCKEYSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10318 GELDING DRIVE

10f. Zip Code: 21030

10g. Citizan of Whet Country?: U.S.A.

11. Marital Stetus: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12):

College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MORTGAGE BANKER

16b. Kind of Business/Industry: BANKING

17. Father's Name (First, Middle, Last): JOHN LEO MUELLER, JR.

18. Mother's Name (First, Middle, Maiden Surname): ARLENE ELIZABETH PELTO

19a. Informent's Name/Reletionship (Type, Print): CHARLES WILLIAM MUELLER/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 NORTH RITTERS LANE, OWINGS MILLS,MD. 21117

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Steta 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL GARDENS

Date: 1/13/97

20c. Location - City or Town, Steta: TIMONIUM,MARYLAND

21. Signeture of Funeral Service Licensaa: Victor Lengrand, Jr. VICTOR LENGRAND, JR.

22. Name end Address of Facility: LEMMON FUNERAL HOME OF DULANEY,INC. 10 W. PADONIA ROAD, TIMONIUM, MD. 21093

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or raspiratory arrest, shock, or heart feilure. List only one causa on aach line.

Approximeta Interval Between Onset end Deeth

Immedlete Cause (Finel disease or condition resulting in deeth) a. Small Cell Cancer of the lung — 3 Month

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Dua to (or es a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not reeulting in the underlying cause given in Part I.

23b. Did tobacco uss contributa to the causs of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Piece of Death (Check only one) Hospitel: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Rasidence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, straet, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2 [ ] Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: Ayman F. Akkad, M.D.

29c. Licansa number: D42736

29d. Data signed (Month, Day, Year): JANUARY 10,1997

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): DR. AYMAN F. AKKAD 7600 OSLER DRIVE,SUITE 203, TOWSON,MD. 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrer's Signeture: Julie Henderson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

97-149-510
AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00360

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH EARL MARTIN
2. Date of Death Month Day Year: JAN.08,1997
3. Time of Death: 2150 P
4a. Facility Name *(If not institution, give street and number)*: 6506 EBERLE DR. APT.102
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-7033
6. Sex: 1 ☐ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 3,1921
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 6506 Eberle Drive
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — If Yes, Give Year or Dates: 6/29/43 to 2/11/46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steel Worker
16b. Kind of Business/Industry: Rustlers Industry

17. Father's Name *(First, Middle, Last)*: Joseph E. Martin Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Elizabeth Jefferson

19a. Informant's Name/Relationship *(Type, Print)*: Georgia V. Neal (Sister)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6506 Eberle Dr. Apt. 102 Balto., Md. 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet — Date: 1/13/97
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Caple Funeral Service, 5502 WINNER AVENUE BALTIMORE, MD. 21231

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? Inquiry — 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JAN.09,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

97-0117-510
asp ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-743 1/18/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00361

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MARK		McCALL	JAN 07 1997	2:21 A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4407 CLYSDALE AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-72-5120	1 [X] M 2 [ ] F	37 Yrs.			Nov. 3,1959	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Lutherville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1311 Warwick Drive	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X	1 [ ] Yes 2 [X] No Specify: X	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4 yrs	Sales Representative	Computer Software

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Aubrey C. McCall	Barbara Giles Barnett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Aubrey C. McCall	800 Oak Hill Court, Baltimore, Maryland 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Green Mount Crematory	1/9/97	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Martin D. Lawson	Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC INTOXICATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation [X] Could not be determined	FOUND 1-7-97	UNKNOWN M	1 [ ] Yes [X] No	UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND AT HOUSE	4407 CLYSDALE AVE. BALTIMORE, MD.

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E	JANUARY 07, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 1997	[signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 00362

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD R. MITCHELL
2. DATE OF DEATH (Month, Day, Year): JANUARY 06, 97
3. TIME OF DEATH: 2[15] A M
4. SOCIAL SECURITY NUMBER: 214-22-5791
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar. 7, 1927
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Bayview Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore -Dundalk
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2716 Dunbrook Ct., Apt. A
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Rigger
16b. KIND OF BUSINESS/INDUSTRY: Shipyard
17. FATHER'S NAME (First, Middle, Last): Peter Mitchell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Cammarta
19a. INFORMANT'S NAME (Type/Print): Sarah Mitchell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2716 Dunbrook Ct., Apt. A Balto., Md. 21222
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Chesapeake Crematory 1-8 — DATE
20c. LOCATION — City or Town, State: -97 Beltsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Baltimore, Md. 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	malignant effusions	1 wk
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	post-obstructive pneumonia	1 wk
DUE TO (OR AS A CONSEQUENCE OF):		
c.	advanced lung cancer	1 month (dx'd 12/96)
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD Johns Hopkins Bayview Medical Ctr.
29c. LICENSE NUMBER: 96705
29d. DATE SIGNED (Month, Day, Year): 01/06/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Colky MD JHBMC Medical Housestaff
31. DATE FILED (Month, Day, Year): JAN 10 1997
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

5x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00363

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRISON MOSLEY

2. Date of Death — Month: JAN Day: 2nd Year: 1997

3. Time of Death: 9.40 A.M.

4a. Facility Name *(If not institution, give street and number)*: HOSPITAL - CHURCH HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212468817

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 24, 1948

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 512 N. Kenwood Ave.

10f. Zip Code: 21205

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th Grade — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction Worker

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: Harrison Mosley, Sr. /Father

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy M. Bulls

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Arrington /sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 512 N. Kenwood Ave. Baltimore, MD. 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion Cemetery — Date: 1/8

20c. Location - City or Town, State: Landsdowne, MD.

21. Signature of Funeral Service Licensee: ▶ Kevin Parker

22. Name and Address of Facility: Kevin A. Parker Funeral Service 3572 Frederick Ave. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Massive Bleeding From Mouth

Due to (or as a consequence of):
b. Squamous Cell Carcinoma of Tongue

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sunil Ahuja

29c. License number: D28762

29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUNIL AHUJA 100 N. BROAD WAY BALTIMORE, MD 21231

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Lillian Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00364

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: VIRGINIA G. MARTIN
2. Dete of Death Month: JAN. Dey: 6 Yeer: 97
3. Time of Death: 6:55AM
4a. Feclity Neme *(If not institution, give street and number)*: ANNE ARUNDEL GEN. ANNAPOLIS
4b. City, Town, or Location of Deeth: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 242-38-3314
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. lest birthday)*: 86 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: July 10, 1910
9. Birthplece *(Stete or Foreign Country)*: S. CAROLINA

Usuel Residence of Decedent

10a. Stete: MD.
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 7807 WINDSOR DRIVE APT. B
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1☐ Never Merried 2☐ Merried 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 10TH | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC
16b. Kind of Business/Industry: HOME

17. Father's Neme *(First, Middle, Last)*: ARTHUR THOMPSON
18. Mother's Neme *(First, Middle, Meiden Surname)*: GRACE HAMILTON

19a. Informant's Neme/Reletionship *(Type, Print)*: MARGARET GRIMSLEY
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7807 WINDSOR DRIVE, GLEN BURNIE MD. 21060

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☑ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, crematory or other place)*: MT. ZION CEM. | Dete: 1/10/97
20c. Location - City or Town, State: LAUREL MD.

21. Signeture of Funerel Service Licensee: [signature]
22. Neme and Address of Feciliy: GARY T. MARCH FUNERAL HOME P.A. 270 FREDERICK RD. BALT. MD. 21229

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximete Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth): e. pneumonia
Due to (or es a consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. respiratory failure
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.
29b. Signeture end title of certifier: [signature]
29c. License number: D-18809
29d. Dete signed *(Month, Dey, Yeer)*: 1/6/97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): B.J. Fowlow 600 Ridgely Ave Annapolis Md 21401

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 10 1997
32. Registrer's Signeture: [signature] Sylvia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00365

Item : 7, per F.H. G-743 1/10/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN MOORE

2. Date of Death: Month 01 Day 07 Year 1997

3. Time of Death: 10:25 PM

4a. Facility Name (If not Institution, give street and number): CHURCH HOSPITAL 1000 BROADWAY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: CITY

Funeral Director

5. Social Security Number: 228078612

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 ~~82~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR. 12, 1913

9. Birthplace (State or Foreign Country): VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1214 N. MONTFORD AVENUE

10f. Zip Code: 21213

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): NONE; College (1-4or 5+): NONE

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): JANITOR

16b. Kind of Business/Industry: BETHLEHEM STEEL CO.

17. Father's Name (First, Middle, Last): LEE MOORE

18. Mother's Name (First, Middle, Maiden Surname): INDIANA FOSTER

19a. Informant's Name/Relationship (Type, Print): JOAN HARVEY - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 N. MONTFORD AVE. BALTO, MD. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: JANUARY 11, 1997

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Calvin B. Scruggs Jr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA.

Due to (or as a consequence of):

b. RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-16188

29d. Date signed (Month, Day, Year): 01/09/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WALKER IOMPAGLIATELLI, 121 S. EATON ST. BALT, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Lisa Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed therein by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REGINA NIECE

2. Date of Death: Month JANUARY Day 6 Year 1997

3. Time of Death: 7.25 AM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER, 3001 SOUTH HANOVER STR.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212 07 1072

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 17, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 213 Orchard Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Stephen Chychla

18. Mother's Name (First, Middle, Maiden Surname): Mary Ofertowicz

19a. Informant's Name/Relationship (Type, Print): Teresa Niece / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 857 Swift Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk.

Date: 1/8/97

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Zaminowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c. ENCEPHALOPATHY

Due to (or as a consequence of):

d. HYPERTENSION

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kamler MD

29c. License number: AS 244 1616

29d. Date signed (Month, Day, Year): JANUARY 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAN KAMLER, MD HARBOR HOSPITAL CENTER, 3001 SOUTH HANOVER STR. BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Madison-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JACQUELINE	CONCETTA	NOVAK	JANUARY 9, 1997	7:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SAINT JOSEPH MEDICAL CENTER	TOWSON, MARYLAND	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-30-1135	1☐ M 2☒ F XX	64 Yrs.			APR. 12 1932	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	CARROLL	Eldersburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2108 Harvest Farm Road	21784	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Bianca	Edith Dirusco

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward F. Novak (husband)	2108 Harvest Farm Rd. Eldersburg MD 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Garrison Forest	1/13/97	Owings Mills MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian D Haight	Haight Funeral Home P.O. Box 195 Sykesville MD 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GASTROINTESTINAL BLEEDING	1 DAY
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted eventa resulting in death) Last	b. ESOPHAGEAL ULCERATION	2 DAYS
Due to (or as a consequence of):		
	c. PERITONEAL CARCINOMATOSIS	2 YEARS
Due to (or as a consequence of):		
	d. METASTATIC CANCER OF THE BREAST	20 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D 10091	1/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARTHUR A. SERPICK, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 1997	Gina Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE ROSE OAKS
2. Date of Death (Month, Day, Year): JANUARY 8, 1997
3. Time of Death: 5:50 PM
4a. Facility Name (If not institution, give street and number): 2300 FURNACE ROAD
4b. City, Town, or Location of Death: FALLSTON
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-05-9866
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 21, 1919
9. Birthplace (State or Foreign Country): BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: FALLSTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2300 FURNACE ROAD
10f. Zip Code: 21047-1046
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TELEPHONE OPERATOR
16b. Kind of Business/Industry: TELEPHONE INDUSTRY

17. Father's Name (First, Middle, Last): CHARLES MAXA
18. Mother's Name (First, Middle, Maiden Surname): MARY JANDA

19a. Informant's Name/Relationship (Type, Print): JOHN W. OAKS (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2300 FURNACE ROAD FALLSTON, MARYLAND 21047-1046

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.
Date: JANUARY 9, 1997
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signeture of Funeral Service Licensee: Heather Lassahn
22. Name and Address of Fecility: E.F. LASSAHN FUNERAL HOME, P.A. 11750 BELAIR ROAD KINGSVILLE, MARYLAND 21087-1351

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. metastatic carcinoid tumor — 18 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tillery Hahn M.D., Ph.D.
29c. License number: C2205
29d. Date signed (Month, Day, Year): January 09, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johns Hopkins Oncology Center 600 N. Wolfe St. Baltimore MD 21287

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00369

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ann NORA O'Connell

2. Date of Death Month Day Year: Jan 08 1997

3. Time of Death: 1410

4a. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-12-5817

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 104 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 1, 1892

9. Birthplace *(State or Foreign Country)*: IRELAND

Usual Residance of Decedant

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 713 MAIDEN CHOICE LANE - APT-2209

10f. Zip Coda: 21228

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowad 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Dacedant's Education *(Specify only highast grada completed)*: Elamantary/Secondery (0-12): 10TH GRADE; Collega (1-4or 5+):

16a. Dacedant's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: CLAIMS EXAMINER

16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Fathar's Nama *(First, Middla, Last)*: JAMES O'CONNELL

18. Mother's Nama *(First, Middla, Maidan Surname)*: ANNE KEARNS

19a. Informant's Neme/Ralationship *(Type, Print)*: JAMES E. CLARDY (NEPHEW)

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 1903 S. 69TH STREET - PHILADELPHIA, PA. 19142-1201

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of camatary, crematory or other place)*: NEW CATHEDERAL CEMETERY

Data: 1/11/97

20c. Location - City or Town, Stata: BALTIMORE

21. Signature of Funaral Service Licansee: Louise E. Hubbard

22. Name and Addrass of Facility: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complicetions that caused the death. Do not entar the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach line.

Approximata Intarval Between Onsat and Death

Immadiata Cause (Final disaasa or condition resulting in death)

a. Dehydration — 1 week

Due to (or as a consequence of):

b. Anorexia — 3 mos

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or injury thet initiated events resulting in death) Last

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

Lower gastrointestinal bleed

Vaginal bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to compiation of causa of death? 1☐ Yes 2☒ No

25. Wes casa refarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, death occurred at the time, data and placa, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to tha causa(s) and mannar stated.

29b. Signeture and titla of certifier: Myla M Carpenter MD

29c. Licansa number: D30989

29d. Data signed *(Month, Day, Year)*: Jan 08 1997

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Myla M Carpenter MD 711 Maiden Choice Ln Catonsville

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Madison-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00370

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur H Poltrok

2. Date of Death Month: January Day: 3 Year: 1997

3. Time of Death: 0145 Am

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 198 03 0831

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 6, 1912

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 849 Nabbs Creek Road

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Maryland Drydock

17. Father's Name *(First, Middle, Last)*: Casper Poltrok

18. Mother's Name *(First, Middle, Maiden Surname)*: Rica Arnold

19a. Informant's Name/Relationship *(Type, Print)*: Marian Poltrok / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 849 Nabbs Creek Road Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. | Date: 1/4/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zaminowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D 42820

29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Christopher DeBorja 3708 Mountain Road Pasadena, Maryland 21122

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00371

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK M. PARYNIS

2. Date of Death: Month 1 Day 7 Year 97

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): 740 S. LINWOOD AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-09-9634

6. Sex: 1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday): 83 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 11-4-13

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 740 S. LINWOOD AVENUE

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST

16b. Kind of Business/Industry: AM. STANDARD

17. Father's Name (First, Middle, Last): VINCENT PARYNIS

18. Mother's Name (First, Middle, Maiden Surname): KAROLINE KRAWCZYK

19a. Informant's Name/Relationship (Type, Print): MRS. ESTHER PARYNIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 740 S. LINWOOD AVENUE BALTO. MD. 21224

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ENTOMBED

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY

Date: 1-10

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CANCER OF KIDNEY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. [illegible]

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D15634

29d. Date signed (Month, Day, Year): 1-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN GRUNGAM 3411 Bank Street Balto MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00372

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eula Bell Reed

2. Date of Death (Month, Day, Year): January 5, 1997

3. Time of Death: 9:00AM

4e. Facility Name (If not institution, give street and number): 3302 Windsor Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215-16-0514

6. Sex: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 7, 1915

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No XX

10e. Street and Number: 3302 Windsor Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Private Families

17. Father's Name (First, Middle, Last): Jesse L. Reed

18. Mother's Name (First, Middle, Maiden Surname): Rosa Fisher

19a. Informant's Name/Relationship (Type, Print): Donette Green grand daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 902 Masefield Road Baltimore, MD 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) X

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: Jan 10

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Jerry L. Nutter

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic Heart Disease with probable Acute Myocardial Infarction — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary artery Disease — Due to (or as a consequence of): — 10 yrs

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

S/p permanent cardiac pacemaker
Peripheral Vascular Disease
H/O Hypertension & Congestive Ht. Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D10152

29d. Date signed (Month, Day, Year): 1-9-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELIJAH SAUNDERS M.D. 419 WEST REDWOOD ST. BALTIMORE, MD. 21201-1734

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY E. REAL
2. Date of Death (Month, Day, Year): January 9, 1997
3. Time of Death: 9:12 p.m.
4a. Facility Name (If not institution, give street and number): Multi-Medical Nursing Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-40-9250
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 28, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2656 Bailey Road
10f. Zip Code: 21050
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Harry L. Thompson
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Bilz

19a. Informant's Name/Relationship (Type, Print): Joan Mitchell (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 296 L. Canterbury Road, Bel Air, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.
Date: 1/13/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Matthew
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD. 21236

Physician /Medical Examiner

23a. Part1. Enter the diseese, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. CEREBRO VASCULAR ACCIDENT

Due to (or as a consequence of):
b. ATRIAL FIBRILLATION

Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

Due to (or es a consequence of):
c. URINARY BLADDER TUMOURS

Due to (or es a consequence of):
d. CORONARY ARTERY DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Mahmood MD
29c. License number: D45921
29d. Date signed (Month, Day, Year): 1-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Syed Mahmood 4 C NORTH AVENUE SUITE 424 BEL AIR MARYLAND 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Meryland permit. Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00374

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELSIE GOEBEL RHEIN

2. Date of Death Month Day Yaer: Jan. 9, 1997

3. Time of Death: 3:05 PM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Center-Ruxton

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 217-54-9823

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 11, 1899

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7001 North Charles Street

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaer or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:* X

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 yrs; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaking

16b. Kind of Business/Industry: Own Residence

17. Father's Name *(First, Middle, Last)*: August Karl Goebel

18. Mother's Neme *(First, Middle, Maiden Surname)*: Julia Warmuth

19a. Informant's Neme/Reletionship *(Type, Print)*: Mrs. Elaine R. Hyson (Dgter)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2009 Eastridge Road, Timonium, Maryland 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Steta 4☐ Donetion 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetary, cremetory or other plece)*: Green Mount Crematory

Data: 1/11/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Nama and Addrass of Facility: Mitchell-Wiedefeld Home, 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or raspiratory arrest, shock, or haert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseesa or condition resulting in deeth): e. STroke — 1 Month.

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury that initieted events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings availeble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Couid not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner es stated. 2☐ **Medicat Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: A.H. Ghiladi

29c. License number: D-12894

29d. Deta signed *(Month, Day, Year)*: 1-10-97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): A.H. Ghiladi, M.D., 7600 Osler Drive, Towson, Maryland 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 1 0 1997

32. Registrar's Signature: Julia Dorsey Rudel

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL RISKIN

2. Date of Death (Month, Day, Year): JANUARY 05, 1997

3. Time of Death: 12:00 NOON

4a. Facility Name (If not institution, give street and number): 2102 LAKEWOOD STREET

4b. City, Town, or Location of Death: SUITLAND

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-46-5427

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 2, 1935

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 XX Yes 2 ☐ No

10e. Street and Number: 2102 Lakewood Street

10f. Zip Code: 20746

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1 Year

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Technician

16b. Kind of Business/Industry: Prince Georges Community College

17. Father's Name (First, Middle, Last): Max Riskin

18. Mother's Neme (First, Middle, Meiden Surname): Frieda Dunayer

19a. Informent's Name/Reletionship (Type, Print): Albert Roskin

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 10802 Knoll Court, Upper Marlboro, Maryland 20772

20a. Method of Disposition: XX Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Nema of cemetery, cremetory or other piece): Mount Lebanon Cemetery Date: 1/7/1997

20c. Location - City or Town, Stata: Adelphi, Maryland

21. Signature of Funerel Service Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D. C. 20012

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that causedthe death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death

Immediete Cause (Final disaesa or condition resulting in death): e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es a consequence of):

Sequentielly iist conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Last

b.

Dua to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings avaliable prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel examiner? 1 X Yes 2 ☐ No

26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not ba determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and menner as steted. 2 X **Medical Examiner**: On the basis of examinetion and/or investigetion, In my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DEPUTY MEDICAL EXAMINER

29c. License number: D33954

29d. Date signed (Month, Day, Year): JANUARY 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F GOLLE JR M.D. 3001 HOSPITAL DRIVE, CHERVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

10

To Be Completed by Funeral Director

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Have this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 4c, per F.H. G-743 1/10/97 reb

Certificate of Death

Reg. No. 97 00376

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty J. Rohrback
2. Date of Death (Month, Day, Year): January 5, 1997
3. Time of Death: 5:35 PM
4a. Facility Name (If not institution, give street and number): 3032 Keswick Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: ~~Baltimore City~~ N/A

Funeral Director

5. Social Security Number: 215-34-3082
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3032 Keswick Road
10f. Zip Code: 21211
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Ronald Rohrback (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3032 Keswick Road, Baltimore, Maryland 21211

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 1/9/97
20c. Location - City or Town, State: Towson, Maeyland

21. Signature of Funeral Service Licensee: Lynn Burgee Henss
22. Name and Address of Facility: Burgee-Henss Funeral Home 21211, 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ARRY Mmia	acute
Due to (or as a consequence of):	b. Arteriosclerotic Cardiovascular Disease	23 mm
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Transitional Cell Carcinoma of the Kidney
Adenocarcinoma of the Lung

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sheldon Goldgeier MD
29c. License number: MD-D02397
29d. Date signed (Month, Day, Year): 1-6-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sheldon Goldgeier MD 711 W 40'Street Baltimore MD 21211

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Joshua Davidson-Kendell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours and this certificate has been signed by the attending physician and **To the Funeral Director:** This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NINO VICTOR RAINALDI

2. Date of Death Month January Day 5, Year 1997

3. Time of Death: 10:22 PM

4a. Facility Name *(If not institution, give street and number)*: 1510 Patapsco Street 21230

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-34-4694

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 1 1937

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1510 Patapsco Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired Clerk

16b. Kind of Business/Industry: Social Security Admin.

17. Father's Name *(First, Middle, Last)*: Joseph Rainaldi

18. Mother's Name *(First, Middle, Maiden Surname)*: Carmela Pauline Mancinelli

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Alice M. Parker (Fiance)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1510 Patapsco St., Baltimore, Maryland 21230

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Mem. Pk. Jan.

Date: 9, 1997

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Kevin E. Ecker

22. Name and Address of Facility: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225-1856

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Non-small cell Carcinoma of the Lung

Due to (or as a consequence of):

b. Mtl Brain Metastases — 9 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 031551

29d. Date signed *(Month, Day, Year)*: January 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Russell R. DeLuca, M.D. 3001 S. Hanover Street, Baltimore, Md. 21225

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Linda Hudson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00378

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): RUTH ROSEN

2. Dete of Deeth — Month: JANUARY Dey: 2 Yeer: 1997

3. Time of Deeth: 1045 PM

4e. Fecility Neme (If not institution, giva street end number): HARBOR HOSPITAL CENTER, 3001 SOUTH HANOVER STR.

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 228-09-4550

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 79 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): May 28, 1917

9. Birthpiece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1014 Druidon Court

10f. Zip Code: 21225

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementery/Secondary (0-12): 6th

College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Fether's Neme (First, Middle, Last): John Nicholas Bougourd

18. Mother's Neme (First, Middle, Meiden Surneme): Della Harriet Keeler

19e. Informent's Neme/Relationship (Type, Print): John Jewer (Son-in-law)

19b. Meiling Address (Street end Number or Rurei Route Number, City or Town, Steta, Zip Code): 2819 Plover Drive, Unit 47 Ocean City, MD. 21842

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Dulaney Valley Mem. Gardens

Dete: 1/6/97

20c. Location - City or Town, Steta: Timonium, Md.

21. Signature of Funeral Service Licensee: Kevin E, Ecker

22. Neme end Address of Feciliity: MC Cully Funeral Home of Brooklyn 237 E. Patapsco Ave. Balto., MD. 21225

Physician /Medical Examiner

23a. Part1. Enter tha diseesa, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on aach line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Final diseese or condition resulting in deeth)

e. HEMORRHAGIC CEREBRAL INFARCTION

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest

b. MYOCARDIAL INFARCTION

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

ASCVD

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☑ No

28. Place of Deeth (Check only one)

Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mennar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, deeth occurred et tha time, dete end plece, end due to the ceuse(a) end menner steted.

29b. Signeture end title of certifier: Kamler 9155, MD

29c. License number: AS 244 1616

29d. Dete signed (Month, Day, Yeer): JANUARY 2, 1997

30. Neme end eddress of person who completed causa of deeth (Item 23a) (Type, Print): KAMLER, MD, HARBOR HOSPITAL CENTER, 3001 SOUTH HANOVER CTR., BALTIMORE

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 1997

32. Registrer's Signeture: Hudson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00379

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Marie Retz
2. Date of Death: Month: January Day: 4 Year: 1997
3. Time of Death: 8pm
4a. Facility Name (If not institution, give street and number): Gilchrist 6601 N. Charles Street
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-24-1004
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): March 12 1929
9. Birthplace (State or Foreign Country): Altoona, PA.

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Howard Co.
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 Pfister Street
10f. Zip Code: 20723
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Bleck, White, etc. Specify: white

15. Decedent's Edecetion (Specify only highest grade completed): Elementary/Secondery (0-12): 12 College (1-4or 5+): 0
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mass media roller
16b. Kind of Business/Industry: Dargus Assoc. Co.

17. Father's Name (First, Middle, Last): George Walls
18. Mother's Name (First, Middle, Maiden Surneme): Edna M. Clapper

19e. Informant's Name/Relationship (Type, Print): William F. Retz, Sr./husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 28 Pfister Street Laurel, Md. 20723

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Park
Date: JAN. 07 1997
20c. Location - City or Town, Stete: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Eugene J. Lentz
22. Name end Address of Feciliity: McCully Funeral Home of South Balto. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. metastatic lung cancer — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year): NA
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: W. A. R. Tey
29c. License number: 025205
29d. Date signed (Month, Dey, Year): JANUARY 5, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): W. A. R. Tey GBMC 6701 N. Charles St. Balto, Md. 21204

State Registrar

31. Date filed (Month, Day, Yeer): JAN 10 1997
32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00380

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY REMMEY

2. Date of Death Month Day Year: JANUARY 05, 1997

3. Time of Death: 2:15PM

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215-05-9336

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 12 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 514 E. Fort Ave.

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife/domestic

16b. Kind of Business/Industry: Homeowner

17. Father's Name *(First, Middle, Last)*: George Perina

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Broanick

19a. Informant's Name/Relationship *(Type, Print)*: George W. Remmey Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 514 E. Fort Ave. Baltimore, Md. 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: JAN. 08 1997

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: David A. Naylor

22. Name and Address of Facility: McCully Funeral Home of South Balto. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — SEVERAL YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIABETES MELLITUS — TYPE II — SEVERAL YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERLIPIDEMIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MARY JUDELINE MINGUITO, M.D.

29c. License number: AS2441614-22

29d. Date signed *(Month, Day, Year)*: JANUARY 05, 1997

30. Name and address of person who completed cause of death (Item 29e) (Type, Print): MARY JUDELINE MINGUITO, M.D. HARBOR HOSPITAL CENTER BALTIMORE, MARYLAND 21225

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Lisa Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Carroll Ridgell, Jr.

2. Date of Death: Month Jan. Day 8 Year 1997

3. Time of Death: 0430

4a. Facility Name (If not institution, give street and number): Deaton Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-26-6418

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 19, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2655 Dulaney Street

10f. Zip Code: 21223

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Salesman

16b. Kind of Business/Industry: Eastern Overall

17. Father's Name (First, Middle, Last): Edward C. Ridgell, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Hazel Barnes

19a. Informant's Name/Relationship (Type, Print): Edward C. Ridgell, III (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2692 Dulaney St, Baltimore, MD 21223

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 01/10/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Jackie D. Shannon

22. Name and Address of Facility: HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave, Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	UNRESOLVED PNEUMONIA (REPEATED)	2 Weeks
Due to (or as a consequence of): b.	DEMENTIA / CEREBROVASCULAR ACCIDENT	1970
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DECUBITUS ULCER

CONTRACTURES

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P.G. Flynn MD

29c. License number: DO 1346

29d. Date signed (Month, Day, Year): 1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES P.G. FLYNN MD DEATON SPECIALTY HOSPITAL, 611 S. CHARLES BALTIMORE MD 21230

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: L. Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3 of 1

ITEMS: 20a,20b, PER F.H. FILM g-743
1/10/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00382

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MAMIE E. SMITH
2. Date of Death Month / Day / Year: JANUARY 8 1997
3. Time of Death: 1845
4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-20-9736
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 6, 1916
9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3707 Harlem Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:* Black
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stamp Examiner
16b. Kind of Business/Industry: Bureau of Engraving

17. Father's Name *(First, Middle, Last)*: Jacob Oscar Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Katie L. Johnson

19a. Informant's Name/Relationship *(Type, Print)*: sister Ellen I. Smith
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3707 Harlem Avenue Baltimore, Md. 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)*: INURNMENT
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL PARK ~~Metro Crematory~~ | Date: Jan 15
20c. Location - City or Town, State: Baltimore County, MD

21. Signature of Funeral Service Licensee: Ernest R. Fenny, Jr.
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ENDSTAGE CONGESTIVE CARDIOMYOPATHY
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DM, HBP, S/P (L) BKA, HEPATITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C. Ravi MD
29c. License number: D37333
29d. Data signed *(Month, Day, Year)*: JANUARY 8, 1996
30. Name and address of person who completed cause of death (item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Julia Strickler-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Please see items 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-0106-510
97-006
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00383

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): MAREK SZARIAKOW
2. Data of Death — Month: JAN. Day: 6, Year: 1997
3. Time of Death: 2:28 AM
4a. Facility Nama (If not institution, giva straat and number): 3200 blk. MORAVIA ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Sacurity Number: unk.
6. Sax: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 35 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): NOV 8, 1961
9. Birthplaca (State or Foreign Country): Poland

Usual Rasidanca of Decedant

10a. Stata: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Numbar: 603 South Ann St. Apt. 609
10f. Zip Coda: 21231
10g. Citizen of What Country?: Poland

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowad 4 [ ] Divorcad
12. Was Dacedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify: X
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highast grada completed) — Elamentary/Secondary (0-12): — Collega (1-4or 5+): 1
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Contractor
16b. Kind of Businass/Industry: General Construction

17. Father's Nema (First, Middle, Last): Stanislaw Szariakow
18. Mothar's Nama (First, Middle, Maiden Surnama): Teresa Sobotka

19a. Informant's Name/Ralationship (Typa, Print): Stanislaw Szariakow/father
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 603 South Ann St. Apt. 609 Balto., MD 21231

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Spacify)
20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Metro Crematory, Inc. — Data: 1/9/97
20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Sarvica Licensee: Dawn F. McDonald — Dawn F McDonald
22. Nama and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona ceusa on aach lina.

Approximata Interval Batween Onsat and Death

Immediata Causa (Finel disaasa or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated events resulting in daath) Last:
b.
Due to (or as a consequanca of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa raterrad to medical examiner? [XX] Yas 2 [ ] No
26. Placa of Death (Check only ona) — Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [XX] Othar (Specify) ROADWAY

27. Mannar of Death: 1 [ ] Natural 2 [X] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Yaar): found 1-6-97
28b. Tima of Injury: 0228 AM
28c. Injury at Work? 1 [ ] Yas 2 [X] No
28d. Dascribe how injury occurred: PASSENGER IN CAR, STRUCK TREE
28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify): ROADWAY
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata): 3200 BLK MORAVIA RD. BALTIMORE MD

29a. Certifiar (Check only one): 1 [ ] Certifying Physician: To the bast of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. [XX] Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the causa(s) and mannar stated.

29b. Signatura and titla of certifiar: Marjorie Arnold Snyder
29c. Licansa number: O.C.M.E
29d. Data signed (Month, Day, Year): JAN. 6, 1997

30. Nama and addrass of parson who complatad cause of daath (Item 23a) (Type, Print): MARJORIE A. SNYDER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Year): JAN 10 1997
32. Registrar's Signatura: Julia Davidson Rudolph

DHMH 16 Rev 6/95

(4)

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Hamilton Scherer
2. Date of Death Month Day Year: Jan. 8, 1997
3. Time of Death: 7:20pm
4a. Facility Name (If not institution, give street and number): Holly Hill Manor
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 163-01-1078
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 24, 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 919 Ellendale Drive
10f. Zip Code: 21286
10g. Citizan of What Country?: USA

11. Marital Status: 1 ☐ Naver Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yas, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yas 2 X No Specify:
14. Rece - American Indian, Bleck, White, atc.: Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plant Manager
16b. Kind of Business/Industry: Paper Box Company
17. Father's Name (First, Middle, Last): Harry Scherer
18. Mother's Neme (First, Middle, Meiden Surname): Anna Gibson
19a. Informant's Name/Relationship (Type, Print): Treva H. Scherer/wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 919 Ellendale Dr. Towson, MD 21286
20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Metro Crematory, Inc. Date: 1/9/97
20c. Location - City or Town, State: Baltimore, MD
21. Signeture of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Feciility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiec or respiretory errast, shock, or heart failure. List only ona ceuse on each line.

		Approximata Interval Between Onset and Deeth
Immediate Cause (Final disaase or condition resulting in death) e.	Ischemic cardiomyopathy	4 months
Due to (or es a consequence of):		
Sequentielly list conditions, if any, leeding to Immediete ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last b.	Myocardial infarction	4 months
Due to (or as a consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performad? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical examiner? 1 ☐ Yes 2 X No

28. Plece of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Phyaicien: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as steted. 2 ☐ Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: Marc Sokolow MD
29c. License number: D26534
29d. Date signed (Month, Dey, Yeer): 1/9/97

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): Marc Sokolow, MD 301 St. Paul Place Suite 301 Baltimore, MD 21202

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 10 1997
32. Registrar's Signature: Julia Sheridan Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

(10)

97 00385

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Darlene Smith		2. DATE OF DEATH: MONTH Jan DAY 4 YEAR 97	3. TIME OF DEATH: 0450 M
4. SOCIAL SECURITY NUMBER: 213-72-3761	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 40 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 03/26/56
8. BIRTHPLACE (State or Foreign Country): maryland			

9a. FACILITY NAME (If not institution, give street and number): Deaton Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 611 S. Charles St.	10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ND IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): never worked	16b. KIND OF BUSINESS/INDUSTRY: n/a	
17. FATHER'S NAME (First, Middle, Last): Howard F. Smith	18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy A. Wamsley		
19a. INFORMANT'S NAME (Type/Print): Howard F. Smith, brother	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3344 Hickory Avenue, Baltimore, MD 21211		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery DATE 1/9/97	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Home at Meadowridge 7250 Washington Blvd., Elkridge, Md. 21227		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Anoxic encephalopathy.	1 month
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Seizure disorder.	?
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Hypothyroidism	?
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ ND	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: CPMehta, MD	29c. LICENSE NUMBER: D34974	29d. DATE SIGNED (Month, Day, Year): ▶ Jan. 4-97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5865 Robert Oliver Place, #121, Columbia, MD 21045

31. DATE FILED (Month, Day, Year): JAN 10 1997	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

Items20b,20c 1-10-97 FilmG743 W.H.per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00386

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Daniel, Derrick, Singer, JR.

2. Data of Death Month: JAN. Day: 9 Year: 97

3. Time of Death: 14:45

4a. Facility Name *(If not institution, give street and number)*: Oak Crest, 8820 Walther Blvd, #3422

4b. City, Town, or Location of Death: Parkville, MD

4c. County of Death: Balto.

Funeral Director

5. Social Security Number: 089 09 4987

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 1/3/18

9. Birthplace *(State or Foreign Country)*: NEW ROCHELLE, N.Y.

Usual Residance of Decedant

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Insida City Limits: 1 ☐ Yes 2 XX No

10e. Street and Number: 3422 RIDGELY COURT

10f. Zip Coda: 21234

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 ☐ Navar Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yes 2 X No If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 X No *Specify:*

14. Rece - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Sacondary (0-12): 12 years; Collaga (1-4or 5+): N/A

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: ELECTRICAL CONTRACTOR

16b. Kind of Businass/Industry: CONSTRUCTION

17. Fathar's Nama *(First, Middla, Last)*: DANIEL DERRICK SINGER, SR.

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: EMELIE FRANK

19a. Informant's Name/Ralationship *(Type, Print)*: WINNIFRED V. SINGER / WIFE

19b. Mailing Addrass *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 8820 WALTHER BLVD., APT. #3422, BALTIMORE, MD. 21234

20a. Mathod of Disposition: 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Spacify)*

20b. Piece of Disposition *(Nama of cematary, crematory or other place)*: ~~DULANEY VALLEY MEMORIAL GARDENS~~ Metro Cem.

Data: 1/13/97

20c. Location - City or Town, Stata: ~~Catonsville TIMONIUM~~, MARYLAND

21. Signatura of Funaral Service Licansee: Bryan W. Clary

BRYAN W. CLARY

22. Nama and Address of Facility: LEMMON FUNERAL HOME OF DULANEY, INC. 10 W. PADONIA ROAD, TIMONIUM, MD. 21093

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one causa on each line.

Approximata Interval Batwaen Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. Lymphoma

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

b. Congestive Heart Failure

Dua to (or as a consequance of):

c. Anemia

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 X No

24b. Wara autopsy findings avaliable prior to completion of cause of daath? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 X No

26. Placa of Daath *(Check only ona)*: Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA; Othar: 4 ☐ Nursing Home 5 X Rasidance 6 ☐ Other *(Specify)*

27. Mannar of Death: 1 X Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not ba datarmined

28a. Data of Injury *(Month, Day Yaar)*: N/A

28b. Tima of Injury: M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 X **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: Brian Zable, MD

29c. Licansa number: D0050620

29d. Data signed *(Month, Day, Yaar)*: 1/9/97

30. Nama and address of parson who complatad causa of death (Itam 23a) (Type, Print): BRIAN ZABLE, MD Oak Crest Medical Center, 8800 Walther Blvd, Parkville, MD 21234

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 10 1997

32. Rajistrar's Signatura

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN SMITH

2. Date of Death Month JAN, Day 2, Year 1997

3. Time of Death: 5:00 am

4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON, MARYLAND

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 224-34-6110

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 7-9-30

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 600 FAGLEY STREET

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLIE FALWELL

18. Mother's Name (First, Middle, Maiden Surname): NELLIE MARSHALL

19a. Informant's Name/Relationship (Type, Print): MR. IRVIN SMITH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 FAGLEY STREET BALTO. MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SPRINGHILL CEM ASSO. Date: 1-7-97

20c. Location - City or Town, State: LYNCHBURG, VA

21. Signature of Funeral Service Licensee: Charles K. Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 37254

29d. Date signed (Month, Day, Year): 1/2/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BOON P. LIM, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00388

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: Mary Snowden

2. Dete of Deeth — Month: Jan. Dey: 7, Year: 1997

3. Time of Deeth: 7:00AM

4e. Fecility Name *(If not institution, give street end number)*: 4303 Adelle Terrace

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-18-3475

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 70 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: Feb. 22, 1926

9. Birthpleca *(Steta or Foraign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4303 Adelle Terrace

10f. Zip Code: 21229

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Merried 2☐ Marriad 3☐ Widowed 4☒ Divorced

12. Was Decadent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Black, White, etc. *Specify:* Afro-American

15. Decadent's Education *(Specify only highest greda completed)*: Elementery/Secondery (0-12): 7 — Colleje (1-4or 5+): 0

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Dietician

16b. Kind of Business/Industry: Horn + Horn

17. Fether's Neme *(First, Middle, Lest)*: James Smith

18. Mother's Name *(First, Middle, Maiden Surneme)*: Sarah Johnson

19e. Informent's Name/Relationship *(Type, Print)*: Ms. Shirley Clark-Gillyard (daughter)

19b. Meiling Address *(Streat end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 50 Cobbler Lane Balto. Md. 21229

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: King Memorial — Date: 1/10/97

20c. Location - City or Town, Steta: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Nama and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the moda of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximeta Intarval Between Onset and Deeth

Immediete Ceuse (Finel disaese or condition resulting in death)

e. Acute myelogenous leukemia — Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Diseesa or injury thet initieted events resulting in daeth) Lest

b. — Due to (or es e consequence of):

c. — Due to (or as a consequance of):

d.

Part ii. **Othar significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: congestive heart failure

23b. Did tobecco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy findings avaliable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Rasidence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicat Exeminer:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signatura end titie of certifier: Elizabeth Claire Dees MD

29c. License number: D50325

29d. Dete signed *(Month, Day, Year)*: January 7, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): E. Claire Dees MD 600 N Wolfe St Baltimore MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 10 1997

32. Registrar's Signature: John Davidson Kendall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David W Savin

2. Date of Death (Month, Day, Year): January 8th, 1997

3. Time of Death: 1:53 AM

4e. Facility Name (If not institution, give street and number): Univ. of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 222-38-6604

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9-11-1952

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10e. State: Delaware

10b. County: Kent

10c. City, Town or Location: Dover

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 31 Rockford Crossing

10f. Zip Code: 19901

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12 yr's

College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): David C. Savin

18. Mother's Neme (First, Middle, Maiden Surname): Edith Miller

19e. Informant's Name/Reletionship (Type, Print): Mr David C. Savin - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4520 Hendry Ave. Wilmington, Delaware 19808

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Silverbrook Crematory

Dete: 1/13/97

20c. Location - City or Town, Stete: Wilmington, Delaware

21. Signature of Funeral Service Licensee: Paul L Hatcher

22. Neme end Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	e. Disseminated Intravascular Coagulation	12 hrs.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sepsis	4 days
Due to (or as a consequence of):		
	c. Diabetes Mellitus Type I	30+yrs.
Due to (or as a consequence of):		
	d. End Stage Renal Disease	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

26d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christian M. Fisher MD

29c. License number: P09787

29d. Date signed (Month, Day, Year): Jan. 8, 1997

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Christian M. Fisher 22 S. Greene St Baltimore, MD 21209

State Registrar

31. Date filed (Month, Dey, Year): JAN 10 1997

32. Registrer's Signeture: a Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GREGORY SILVERIO
2. Date of Death Month Day Year: JANUARY 01 97
3. Time of Death: 1708
4a. Facility Name (If not institution, give street and number): UMMS
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 091-26-9627
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 13, 1928
9. Birthplace (State or Foreign Country): Spain

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore County
10c. City, Town or Location: Baltimore (Lansdowne)
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 16 Carling Circle
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Spain
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seaman (AB)
16b. Kind of Business/Industry: Merchant Marine

17. Father's Name (First, Middle, Last): Gregory Paul Silverio
18. Mother's Name (First, Middle, Maiden Surname): Ptra Silverio

19a. Informant's Name/Relationship (Type, Print): Rosalie Mae Silverio (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 Carling Circle Balto., MD. 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park
Date: 1/6/97
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Kevin E. Ecker
22. Name and Address of Facility: McCully Funeral Home of Brooklyn, 237 E. Patapsco Ave. Balto., MD. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	48 HRS.
Due to (or as a consequence of): b.	NEUTROPENIA	9 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	STEM CELL TRANSPLANT	11 DAYS
Due to (or as a consequence of): d.	MANTLE CELL LYMPHOMA	19 MOS.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Cynthia Soriano
29c. License number: P08553
29d. Date signed (Month, Day, Year): 1/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Soriano UMMS

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy M Schellenschlager
2. Date of Death (Month, Day, Year): January 5, 1997
3. Time of Death: 10:25 Am
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-20-9980
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 18, 1927
9. Birthplace (State or Foreign Country): Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 6668 Shelly Road Apt. 19
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+): 0
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John Stauffer
18. Mother's Name (First, Middle, Maiden Surname): Myrtle Hyland

19a. Informant's Name/Relationship (Type, Print): John Schellenschlager/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1540 Palm Court Pasadena, Md. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Pk. Date: 1/8/97
20c. Location - City or Town, State: Dorsey, Md.

21. Signature of Funeral Service Licensee: Eugene J Carter Jr
22. Name and Address of Facility: McCully Funeral Home of Pasadena, 3204 Mountain Road Pasadena, Md. 21122

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death) a. acute M.I.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marc A. Kaplan M.D.
29c. License number: D22110
29d. Date signed (Month, Day, Year): January 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marc A. Kaplan M.D. 7845 Oakwood Rd #300 Glen Burnie Md

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
Registrar's Signature:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00392

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MILDRED ELIZABETH STUMPFEL

2. Deta of Death: Month JAN. Dey 8 Year 1997

3. Time of Daeth: 12:45 A.M.

4e. Facility Neme (If not Institution, give street and number): GENSIS LOCH RAVEN

4b. City, Town, or Location of Deeth: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-34-7155

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): 1/13/14

9. Birthplace (Stete or Foraign Country): MARYLAND

Usual Residenca of Decedent

10e. Stete: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 6401 LOCH RAVEN BLVD. APT. 139

10f. Zip Code: 21239

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:

13. Was Dacadent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Raca - Amarican Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 9th GRADE | College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired): SALES

16b. Kind of Business/Industry: DEPARTMENT STORE

17. Fether's Nema (First, Middle, Last): JEROME WEWERA

18. Mother's Nama (First, Middle, Meiden Surnama): HEDRIGA STERBAK

19a. Informent's Neme/Raletionship (Type, Print): MILDRED L. MANN DAUGHTER

19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 10003 WOODKEY LANE #10 OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or othar place): MORELAND MEMORIAL PARK

Dete: 1/13/97

20c. Location - City or Town, State: HILLENDALE, MD

21. Signeture of Funarel Servica Licensee: [signature]

22. Name end Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications thet caused the death. Do not enter tha moda of dying, such es cardiec or raspiratory arrest, shock, or heart feilura. List only one ceuse on each line.

Approximete Intarvel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Bone Tumor.

Due to (or as e consequence of): b. Cancer colon.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of): c.

Due to (or es a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to complation of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Deta of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, deta end placa, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: Judith K. Tanpalmini

29c. License number: D30661

29d. Date signed (Month, Dey, Year): January 8th 97

30. Name end eddress of person who completed causa of death (Item 23a) (Type, Print): 5670 The Alameda, Baltimore, Md - 21239.

State Registrar

31. Date filed (Month, Dey, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

97-0049-003
CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS TRAGESER JR.
2. Date of Death (Month, Day, Year): JANUARY 03, 1997
3. Time of Death: 0641AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL E.R.
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213 64 4436
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 21, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 640 Opel Road
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: U.S. Gypsum

17. Father's Name (First, Middle, Last): Francis G. Trageser
18. Mother's Name (First, Middle, Maiden Surname): Mary Frances Sager

19a. Informant's Name/Relationship (Type, Print): Patricia Trageser / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 640 Opel Road Glen Burnie, Maryland 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk.
Date: 1/7/97
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: George J. Gonce
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hemopericardium
Due to (or as a consequence of):
b. Ruptured Aortic Root Aneurysm

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jason Lake MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 04, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Item19a 1-14-97 FilmG743 W.H.Per Doctor

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00394

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BETTY MARIE TYLER
2. Date of Death Month Day Year: JAN. 8, 1997
3. Time of Death: 10:26am
4a. Facility Name *(If not Institution, give street and number)*: CROFTON CONVALESCENT CENTER
4b. City, Town, or Location of Death: CROFTON
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 403-10-6966
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT 5, 1908
9. Birthplace *(State or Foreign Country)*: KY.

Usual Residance of Decedant

10a. State: MD.
10b. County: ANNE ARUNDEL CO.
10c. City, Town or Location: CROFTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1624 DRYDEN WAY
10f. Zip Coda: 21114
10g. Citizan of What Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas: X
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X
14. Rece - Amarican Indian, Black, White, etc. Specify: WHITE

15. Decedant's Education *(Specify only highast grada compiated)*: Elamentary/Secondary (0-12): 06 | Collega (1-4or 5+)
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: DECORATOR
16b. Kind of BusInass/Industry: INTERIOR DECORATION

17. Fathar's Nama *(First, Middla, Last)*: WILLIAM HEAD
18. Mothar's Nama *(First, Middla, Maiden Surnama)*: BESSIE HETTINGER

19a. Informant's Name/Ralationship *(Type, Print)*: Joan ~~JEAN~~ C. TITUS
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 1624 DRYDEN WAY CROFTON, MD 21114

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stete 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cremetory or othar place)*: METRO CREMATORY
Data: JAN 9,
20c. Location - City or Town, Steta: BALT MD

21. Signature of Funeral Service Licensee: ▶ Patrick J Crendell
22. Neme end Addrass of Facility: HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS ROAD GAMBRILLS MD 21054

Physician /Medical Examiner

23a. Part1. Enter the disease, complications that causad tha daath. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. Ent only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. Cerebro Vascular Accident — 2 months
Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated avants resulting in death) Last
b.
Dua to (or as a consequanca of):
c.
Dua to (or es e consequance of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examiner? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☑ Nursing Home 5☐ Rasidenca 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D38958
29d. Deta signed *(Month, Day, Year)*: 1/8/97

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Daljeet Singh Sidhu, MD, 1413 ANNAPOLIS ROAD #106, ODENTON MD 21113

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILDA C.E TAYLOR-HINDLE

2. Date of Death: Month JANUARY Day 1 Year 1997

3. Time of Death: 8.55pm.

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL 301 HOSPITAL DRIVE

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL.

Funeral Director

5. Social Security Number: 151-22-1060

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 22,1907

9. Birthplace (State or Foreign Country): Conn.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Millersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 290 W. Pasadena Road

10f. Zip Code: 21108

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles W. Peterson

18. Mother's Name (First, Middle, Maiden Surname): Anna L. Oberg

19a. Informant's Name/Relationship (Type, Print): Hilda Taylor Deckman Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 290 W. Pasadena Road Millersville, Maryland 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc. Date: Jan. 4,1997

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: McCully Funeral Home 3204 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC CARCINOMA	WEEKS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PRIMARY CARCINOMA LUNG	2 YEARS
Due to (or as a consequence of):		
	c. KNOWN CARCINOMA LEFT BREAST	2 YEARS
Due to (or as a consequence of):		
	d. PLEURAL EFFUSION SECONDARY TO SPREAD METASTASES	WEEKS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

* CHRONIC OBSTRUCTIVE PULMONARY DISEASE
* PNEUMONITIS RIGHT LOWER LOBE * ANEMIA
* HYPERTENSION * MULTIFOCAL ATRIAL TACHYCARDIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: , M.D.

29c. License number: D1999[illegible]

29d. Date signed (Month, Day, Year): 1/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID ROSE, M.D. SUITE 500 2001 JESPERSON DRIVE GLEN BURNIE MARYLAND 2106[illegible]

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian C. Thiele

2. Date of Death: Month January, Day 2nd, Year 1997

3. Time of Death: 11 2D/PM

4a. Facility Name (If not institution, give street and number): JOSEPH RICHEY HOSPICE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-01-6310

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 26,1915

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3040 STRICKLAND STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: INSURANCE COMPANY

17. Father's Name (First, Middle, Last): ANTONI RAUSHER

18. Mother's Name (First, Middle, Maiden Surname): MARY BRAUNBART

19a. Informant's Name/Relationship (Type, Print): WILLIAM E. THIELE (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7820 BRIDGE DRIVE - BALTIMORE, MD 21226

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PK

Date: 1/6/97

20c. Location - City or Town, State: ELKRIDGE

21. Signature of Funeral Service Licensee: Teresa L Klug

22. Name and Address of Facility: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia, severe — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GI Bleeding / malnutrition — months

Due to (or as a consequence of):

c. Prob. Ca of lung — months to years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael G. Hayes, MD

29c. License number: D 02290

29d. Date signed (Month, Day, Year): 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael G. Hayes - 827 Linden Ave - Baltimore, Md. 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar: Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-0033-025

AM ITEMS: 23 PART I, II, 27, PER MED FILM G-743 1/10/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00397

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PHOEBE ELIZABETH VEDDA

2. Date of Death Month Day Year: JAN. 02, 1997

3. Time of Death: 1326 P

4a. Facility Name *(If not institution, give street and number)*: 1123 BELCAMP RD.

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 071-18-9802

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 24, 1923

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Streett

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3103 Queens Castle Court

10f. Zip Code: 21154

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Leonard Motta

18. Mother's Name *(First, Middle, Maiden Surname)*: Eleanor Carlock

19a. Informant's Name/Relationship *(Type, Print)*: Venetia E. Gluch (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1332 Salonica Place, Bel Air, MD. 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Green Mount Crematory

Date: 1/6/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ William Paul

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consaquenca of):

Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as e consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause givan in Part I.: ASPIRATION OF FOOD BOLUS

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☒ Yes 2☐ No

25. Was case referrad to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Residenca 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Phyaician**: To the best of my knowledge, daath occurred at tha tima, date and place, and due to the causa(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(a) and manner stated.

29b. Signatura and title of certifier: ▶ Stephen S. Radentz, MD

29c. Licensa number: OCME

29d. Data signed *(Month, Day, Year)*: JAN.03,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funaral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 10 1997

32. Registrar's Signature: ▶ Patricia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00398

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Lee Vanlandingham
2. Date of Death Month: 01 Day: 05 Year: 97
3. Time of Death: 8:15pm
4a. Facility Name *(If not institution, give street and number)*: 2242 E. North Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-20-8527
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 27, 31
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2242 E. North Avenue
10f. Zip Code: 21213-1542
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Baler
16b. Kind of Business/Industry: Industrial

17. Father's Name *(First, Middle, Last)*: Clifford Vanlandingham
18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Strawberry

19a. Informant's Name/Relationship *(Type, Print)*: Lillie Vanlandingham
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2242 E. North Avenue Baltimore, Md. 21213

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Cemetery
Date: 1-09-97
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Frank [illegible]
22. Name and Address of Facility: Baltimore, MD. 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASCVD	>10YRS
Due to (or as a consequence of): b.	DIABETES MELLITUS	15YRS
Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	PERIPHERAL VASCULAR DISEASE	>10YRS
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.: BRONCHITIS HTN

23b. Did tobacco uaa contribute to the cauae of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [✓] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of *examination* and/or investigation, In my opinion, death occurred at the time, date and place, and due to the ceuse(s) and *manner* stated.

29b. Signature and titie of certifier: Ramashankar, MD
29c. License number: #D48046
29d. Date signed *(Month, Day, Year)*: 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rama Shankar M.D. 821 N. EUTAW ST. STE. 308 BALTO. Md. 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Item4a 1-10-97 FilmG743 W.H.Per F/H

97-0062-510
CIP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ETHEL WATTS
2. Data of Death (Month, Day, Year): JANUARY 4, 1997
3. Time of Death: 2:45PM
4a. Facility Name ("Presstman" street and number): 403 ~~PRESSMAN~~ STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Na

Funeral Director

5. Social Security Number: 246-40-8192
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 11-27-32
9. Birthplace (State or Foreign Country): MD

Usual Residance of Decedant

10a. State: MD.
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 403 Presstman Street
10f. Zip Coda: 21217
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Navar Married 2☐ Marriad 3☐ Widowed 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, White, atc. Specify: Black

15. Dacadent's Education (Spacify only highast grada complatad)
Elamantary/Secondary (0-12): 12th Grade
Collega (1-4or 5+): NA
18a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Streamstress
16b. Kind of Businass/Industry: Clothing Factory

17. Fathar's Nama (First, Middla, Last): George Watts
18. Mothar's Nama (First, Middla, Maidan Surnama): Voila Walker

19a. Informant's Name/Relationship (Type, Print): Yvonne Faison
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 403 Presstman Street Baltimore, Md. 21217

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cematary, cremetory or othar place): King Mem. Pk. Cem.
Data: 01-10-97
20c. Location - City or Town, Stata: Randallstown, Md.

21. Signatura of Funaral Sarvica Licensaa: Teresa Wagner
22. Nama and Addrass of Facility: Baltimore, Maryland WM.C. March FH 1101 E. North Avenue 21202

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediate Cause (Final disaasa or condition resulting in daath)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? INSPECTED 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☒ No

25. Was casa raferrad to madical axaminar? 1☒ Yaa 2☐ No
26. Placa of Death (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☐ **Certifying Physician**: To the best of my knowledga, daath occurrad at tha time, data and placa, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifiar: Margarita Korell
29c. Licensa number: O.C.M.E.
29d. Data signed (Month, Day, Year): JANUARY 5, 1996

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): MARGARITA KORELL M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signatura: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
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Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00400

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILTON WEISSMAN

2. Date of Death Month: JAN Day: 1 Year: 1997

3. Time of Death: 7:26 AM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-10-7935

6. Sex: X M 2 F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 3, 1905

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 2445 Lyttonsville Road, #701

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Man

16b. Kind of Business/Industry: Liquor Retail

17. Father's Name *(First, Middle, Last)*: Moses Weissman

18. Mother's Name *(First, Middle, Maiden Surname)*: Frieda Lieberverth

19a. Informant's Name/Relationship *(Type, Print)*: Jean Weissman, Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2445 Lyttonsville Road, #701 Silver Spring, Maryland 20910

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Judean Memorial Gardens

Date: 01/02/1997

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Daya Lieberman

22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction — 1 hr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death *(Check only one)*

Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Taubes MD

29c. License number: D085746

29d. Data signed *(Month, Day, Year)*: JAN 1 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Taubes 8218 Wisconsin Ave Bethesda MD

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00401

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jack Bagby Ward
2. Date of Death Month Day Year: 01/07/1997
3. Time of Death: 9:40AM
4a. Facility Name (If not institution, give street and number): 1717 Singer Rd.
4b. City, Town, or Location of Death: Joppa
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-12-0527
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05/22/1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1717 Singer Rd.
10f. Zip Code: 21085
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INS Salesman
16b. Kind of Business/Industry: Self Prudental Employed

17. Father's Name (First, Middle, Last): William R. Ward
18. Mother's Name (First, Middle, Maiden Surname): Nellie Bagby

19a. Informant's Name/Relationship (Type, Print): Marguerite Ward/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1717 Singer Rd. Joppa, MD. 21085

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: 1/8/97
20c. Location - City or Town, State: Beltsville, MD.

21. Signature of Funeral Service Licensee: Edward S. Ingold
22. Name and Address of Facility: Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. RENAL FAILURE — 2 Months
Due to (or as a consequence of):
b. polyARTERITIS NODUSA — 4 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Paul J Scheel Jr MD
29c. License number: D39882
29d. Date signed (Month, Day, Year): 1/7/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL J Scheel JR MD 720 RUTLAND AVE RMS 958 BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: Julie Davidson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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1041

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 4c, per F.H.G-743 1/10/97 reb

Certificate of Death

Reg. No. 97 00402

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
JOSEPH C. WOLFKILL	JAN	1	1997	900 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Levindale Hebrew Geriatric Center	Baltimore	~~Baltimore City~~ N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-10-3252	XX 1 M 2 F	79 Yrs.					March 5, 1917	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore City	Baltimore	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1317 Appleby Avenue	21209	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married XX 2 Married 3 Widowed 4 Divorced	1 XX Yes 2 No If Yes, Give Year or Dates: WWII	1 Yes 2 XX No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Production Control Manager	Maryland Bolt & Nut Co

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles E. Wolfkill, Sr.	Bertha Semler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Josephine Wolfkill (Wife)	1317 Appleby Avenue Baltimore, Maryland 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
XX 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)	Maryland Veteran Cemetery	1/7/97	Garrison Forest, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Jerry H Carpenter	Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PNEUMONIA	DAYS
Due to (or as a consequence of): b.	ASPIRATION	WKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 XX Unknown	1 Yes 2 XX No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 XX No	Hospital: 1 XX Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 XX **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M. McCabney MD	D45757	JAN 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW McNABNEY 2434 W Belvedere Balt, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 1997	Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

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Baltimore, Maryland 21215-0020

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B+l

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00403

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kermit Wood

2. Date of Death Month: 01 Day: 07 Year: 97

3. Time of Death: 12:45pm

4a. Facility Name (If not institution, give street and number): 2537 Calverton Heights Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-09-9959

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-29-12

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2537 Calverton Heights Ave.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 8th | College (1-4 or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired): Laborer

16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): Charles Wood

18. Mother's Name (First, Middle, Maiden Surname): Katie Wood

19a. Informant's Name/Relationship (Type, Print): Louise Wood - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2537 Calverton Heights Ave. Balto., MD 21217

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest

Date: 1-13-97

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 2yo

Due to (or as a consequence of):

b. Cirrhosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D17097

29d. Date signed (Month, Day, Year): 1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis Rendell MD 2300 Garrison Blvd. 21216

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK WARD
2. Date of Death: Month Jan, Day 2, Year 1997
3. Time of Death: 10.20 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-14-8633
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): SEPT 24 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3607 10th Street
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Maryland Cup

17. Father's Name (First, Middle, Last): Frank Ward, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Lena Parks

19a. Informant's Name/Relationship (Type, Print): Violet G. Ward/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3607 10th Street Baltimore, Md. 21225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: JAN. 06 1997
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ David A Taylor
22. Name and Address of Facility: McCully Funeral Home of South Balto. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Prostate Cancer — one and half year

Due to (or as a consequence of):
b. Cerebro Vascular Accident — Two Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sherif Elassal, M.D.
29c. License number: AS 244614-24
29d. Date signed (Month, Day, Year): Jan 12 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sherif Elassal 3001 S. Hanover Street 21225 - Harbor Hospital Center.

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signature: ▶ Gibson-Kendall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00405

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary M. White

2. Date of Death — Month: January Day: 4, Year: 1997

3. Time of Death: 8:08 a.m.

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 159-14-9875

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 24, 1917

9. Birthplace *(State or Foreign Country)*: Penna.

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7750 Williams Street

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: M.V.A.

17. Father's Name *(First, Middle, Last)*: Albert Metzner

18. Mother's Name *(First, Middle, Maiden Surname)*: (Unknown) Mooney

19a. Informant's Name/Relationship *(Type, Print)*: George P. White / Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7750 Williams St. Pasadena, Md. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md. Vet. Ceme. Crowns. — Date: 1/8/97

20c. Location - City or Town, State: Crownsville , Md.

21. Signature of Funeral Service Licensee: Eugene J Carter

22. Name and Address of Facility: McCully Funeral Home of Pasadena 3204 Mountain Road Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Hypertensive Cardiovascular disease — 5 yrs
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Brainstem Stroke
Arteriosclerotic dementia
Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D41927

29d. Date signed *(Month, Day, Year)*: 1/4/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jorge Perez-Alario 3708 Mountain Rd Pasadena, MD 21122

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothea Mary Yoe

2. Date of Death (Month, Day, Year): January 9, 1997

3. Time of Death: 6:00 a.m.

4a. Facility Name (If not institution, give street and number): Edenwald

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-09-0893

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 103 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 17, 1893

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 800 Southerly Road

10f. Zip Code: 21286

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): Unknown

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): Frederick Herr

18. Mother's Name (First, Middle, Maiden Surname): Margaret Vorath

19a. Informant's Name/Relationship (Type, Print): Mary L. Herr - Sister in Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1302 Airlie Way Apt. E Baltimore, MD 21239-1049

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 1/11/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke — 1d

Due to (or as a consequence of):

b. advanced Alzheimer's type Dementia — 5yr

Due to (or as a consequence of):

c. Chronic ischemic disease — 15yr.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] physician

29c. License number: D29769

29d. Date signed (Month, Day, Year): 1/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eunice Lino D. Albuerne MD 516 N. Rolling Rd Balto.

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature ▶ [signature] Deputy Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00407

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Ellen Zarfoss
2. Date of Death Month Day Year: January 8, 1997
3. Time of Death: 9:40 PM
4a. Facility Name *(If not institution, give street and number)*: Edenwald Retirement Community
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-48-0711
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: February 8,1908
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residance of Decedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yaa 2☒ No
10e. Street and Number: 800 Southerly Rd.
10f. Zip Coda: 21286
10g. Citizan of What Country?: United States

11. Marital Stafus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amaricen Indian, Black, White, atc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grada compliated)*: Elamantary/Secondary (0-12): 12 | Collaga (1-4or 5+)
16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middle, Last)*: Franklin S. Lauer
18. Mothar'a Nama *(First, Middle, Maidan Sumama)*: Elmira Jane Fortney

19a. Informant's Name/Ralationship *(Type, Print)*: James R. Zarfoss/son
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 207 Coldbrook Rd. Timonium, MD 21093

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Druid Ridge Cemetery
Data: 1/13
20c. Locafion - City or Town, Stata: Baltimore

21. Signatura of Funaral Sarvice Licensee: John O. Mitchell IV
22. Nama and Address of Facility: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in daath):
a. respiratory failure — 1/8/97
Due to (or as a consaquanca of):
b. ASCVD — many yrs

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.
NIDDM
arrhythmia
prior CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to complafion of causa of daath? 1☐ Yas 2☒ No

25. Was casa raferrad to madical examinar? 1☐ Yes 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA | Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad
28a. Date of Injury *(Month, Day Yaar)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, streat, factory, office building, atc. *(Spacify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Madical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and tita of cartifiar: Alan Kimmel MD
29c. Licansa number: D25783
29d. Data signed *(Month, Day, Year)*: 1/10/97

30. Nama and addrass of parson who completad cause of death (Item 23e) (Type, Print): A Kimmel 220 W. Cold Spring Lane 21210

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 1997
32. Registrar's Signatura: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

97-0137-005
jhm

ITEMS· 23 PART I, 27, 28a-f,
PER MEO F'ILM g-743 1/30/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 00408

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACK VINCENT ZARO
2. Dete ol Deeth (Month, Day, Year): JANUARY 8, 1997
3. Time of Deeth: 0240 AM
4a. Feciility Neme (If not institution, give streat and number): 2426 HOLLY NECK ROAD SLIP 46
4b. City, Town, or Locetion of Deeth: Essex
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Securlty Number: 287-42-2895
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/16/1945
9. Birthplece (State or Foreign Country): Ohio

Usuel Residence of Decedent

10e. Stete: MD.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐Yes 2☒No
10a. Street end Number: 1113 Beach Rd.
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind ol Business/Industry: Steel Company

17. Father's Neme (First, Middle, Last): Vincent F. Zaro
18. Mother's Name (First, Middle, Maiden Surname): Frances Roske

19a. Inlorment's Name/Reletionship (Type, Print): Vincent F. Zaro/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36250 Lakeshore Blvd. Eastlake, OH. 44095

20a. Method ol Disposition: 1☒Burial 2☐Cremetion 3☐Removel lrom Stete 4☐Donetion 5☐Other (Specify)
20b. Plece of Disposition (Name of cemetery, crematory or other place): All Souls Cemetery
Dete: 1/13/97
20c. Locetion - City or Town, Stete: Chardon, Ohio

21. Signeture of Funeral Service Licentiate: Glen A. Grzyb
22. Nama and Address of Feciility: Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto., MD. 21228

Physician /Medical Examiner

23a. Part1. Enter tha diseese, complications that caused the deeth. Do not enter the mode ol dying, such es cardiec or respiretory errest, shock, or heert leilure. List only one ceuse on aech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth): e. DROWNING

Sequentiellty list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest:
Due to (or es a consequence ol):
b.
Dua to (or es e consequence ol):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1☒Yes 2☐No

25. Wes case referred to medical exeminer? 1☒Yes 2☐No
26. Plece of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE
27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☒Could not be determined
28a. Dete of Injury (Month, Day Year): FOUND 1-8-97
28b. Time of Injury: FOUND AT 12:30 AM
28c. Injury et Work? 1☐Yes 2☒No
28d. Describe how injury occurred: SUBJECT FOUND IN WATER
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify): WATER
28f. Locetion (Street and Number or Rural Route Number, City or Town, State): 2426 HOLLY NECK ROAD, SLIP 46 BALTIMORE CO., MD.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha best of my knowledge, daath occurred et tha tima, date and plece, and due to the causa(s) and mannar as steted.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and menner steted.

29b. Signeture end title ol certifier: Dennis J. Chute MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 8, 1997

30. Name end eddress ol person who completed causa ol daath (Item 23a) (Type, Print): Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 10 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-0114-003

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items: 23 part I,II 27,28a-f per MEO G-746 4/1/97 reb
Items: 23 part I,27 per MEO G-744 2/4/97 reb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLENE F. WOODS

2. Date of Death (Month, Day, Year): JANUARY 5, 1997

3. Time of Death: 1:12 P.M.

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216 48 9987

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 8, 1946

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Riviera Beach

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 161 Meadow Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: U. S. Army

17. Father's Name (First, Middle, Last): Wannie Clone McMillion Sr.

18. Mother's Name (First, Middle, Maiden Surname): Maryanna Terziu

19a. Informant's Name/Relationship (Type, Print): Robert E. Woods / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 161 Meadow Road Riviera Beach, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk.

Date: 1/9/97

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Zramkowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~CARDIAC ARRHYTHMIA~~ HYPOXIC-ISCHEMIC ENCEPHALOPATHY WITH ACUTE INTRACEREBELLAR HEMORRHAGE

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

INCISION AND DRAINAGE OF ABSCESS SECONDARY TO FALL; diabetes mellitus; obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ~~1☒ Natural~~ 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Aug., 1996

28b. Time of Injury: unknown M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: FELL IN GARDEN WITH SUBSEQUENT ABSCESSFORMATION

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 161 MEADOW RD. PASADENA, MD.

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jonathan Lord MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. THOR LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS E. APOSTOLEDES
2. Data of Death Month Day Yaar: JAN. 8 TH, 1997
3. Time of Death: 4:00 P.M.
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-10-9857
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): April 9, 1907
9. Birthplace (State or Foraign Country): Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7604 Carson Avenue
10f. Zip Coda: 21224
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Dacedant Ever in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Spacify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Dacadant's Education (Specify only highest grada complatad): Elamantary/Secondary (0-12): Unknown; Collaga (1-4or 5+):
16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratirad): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama (First, Middla, Last): Arnold Norris
18. Mother's Name (First, Middle, Maiden Surnama): Elsie Schlueder

19a. Informant's Name/Ralationship (Type, Print): Hazel A. Ballistreri/Daughter
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 7604 Carson Avenue Baltimore, MD 21224

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Lorraine Park Cemetery
Data: 1/11/1997
20c. Location - City or Town, Stata: Woodlawn, Maryland

21. Signature of Funaral Sarvice Licensee
22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. UROSEPSIS — DAYS.
Dua to (or as a consaquanca of):
b. URINARY TRACT INFECTION
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.
G. I. BLEEDING
LIVER DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical axaminar? 1☐ Yas 2☒ No
26. Placa of Daath (Check only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Residance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not ba datarmined
28a. Date of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of injury - At homa, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and title of cartifiar: A.P. Nazemi MD
29c. License number: D17322
29d. Date signed (Month, Day, Yaar): JAN. 8. 1997

30. Nama and address of parson who completad causa of daath (Itam 23a) (Type, Print): A. P. NAZEMI, M.D. CHURCH HOSPITAL BALT. MD.

State Registrar

31. Date filed (Month, Day, Yaar): JAN 13 1997
32. Registrar's Signature: Linda Davidson-Pondelle

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Behrendt
2. Date of Death (Month, Day, Year): January 8, 1997
3. Time of Death: 9:35 PM
4a. Facility Name (If not institution, give street and number): Chesapeake Health & Rehabilitation Ctr.
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-03-4627
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 17, 1907
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 451 Broadwater Road
10f. Zip Code: 21012
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 Years | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing Industry

17. Father's Name (First, Middle, Last): Otis Miles
18. Mother's Name (First, Middle, Maiden Surname): Mary B. Gosnell

19a. Informant's Name/Relationship (Type, Print): Blanche Townsend/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8110 Kavanagh Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Morgan Chapel Cem. Date: 01/11/1997
20c. Location - City or Town, State: Woodbine, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Duda-Hack Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arresi, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	1 week
Due to (or as a consequence of):	b. Pneumonia Cerebrovascular Accident	1 Year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Attending Doctor
29c. License number: D21684
29d. Date signed (Month, Day, Year): 1-10-97

30. Name and address of person who completed cause of death (item 23e) (Type, Print): C-V-CYRIAC-MD 8109 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: ▶ [signature] Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00412

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth E Bestpitch
2. Date of Death Month: January Day: 10 Year: 1997
3. Time of Death: 9:40 AM
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 176-20-4002
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 21, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 210 Maple Lane, N.W.
10f. Zip Code: 21061
10g. Citizan of What Country?: United States

11. Meritel Stetus: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Richard V. Stewart
18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel L. Lutman

19a. Informent's Name/Reletionship *(Type, Print)*: William S. Bestpitch / Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 210 Maple Lane, N.W., Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Glen Haven Mem. Pk. — Date: Jan. 15, 1997
20c. Location - City or Town, Stata: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Feciility: Kirkley-Ruddick F.H. 421 Crain Hwy S.E.

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications thet caused tha deeth. Do not entar tha moda of dying, such es cardiec or respiratory arrast, shock, or haart feilure. List only one cause on eech line. — Approximeta Intarval Between Onset end Deeth

Immediete Cause (Finel diseesa or condition resulting in death): e. CONGESTIVE HEART FAILURE
Dua to (or as a consequance of):
Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
b. DIABETES MELLITUS
Due to (or es a consequance of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: CEREBRO VASCULAR ACCIDENT; PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Wes an autopsy performed? 1☐ Yas 2☑ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☑ No

25. Wes case referred to medical exeminar? 1☐ Yes 2☑ No
26. Plece of Daeth *(Check only ona)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residanca 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of injury - At home, ferm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledga, death occurred et the tima, data and place, end dua to tha cause(s) end manner as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred at tha tima, deta end plece, end due to the cause(s) and menner steted.
29b. Signetura and title of certifier: [signature] MD
29c. License number: D43977
29d. Dete signed *(Month, Day, Year)*: January 10 1997
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Angelos Orletis. 301 Hospital Drive Glen Burnie MD 21061.

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 13 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 19a, per R.Wade G-744 2/26/97 reb

Certificate of Death

Reg. No. 97 00413

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN BUCHHOLTZ
2. Data of Death (Month, Day, Yaar): January 7, 1997
3. Time of Death: 9:12 pm
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-36-9962
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): June 16, 1916
9. Birthplaca (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☐ Yas 2☐ No
10e. Street end Number: P.O. Box 5999
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detas:
13. Was Decedent of Hlspanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: white
15. Decedent's Education (Specify only highest greda completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 3
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Buainess/Industry: Medical
17. Father's Name (First, Middla, Lest): Herman Miller
18. Mother's Name (First, Middle, Meiden Surnema): Fannie Marie Frantz
19e. Informent's Neme/Reletionship (Type, Print): BUCHHOLTZ William ~~Buckholtz~~/son
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8218 Ermington Dr., San Antonio, Texas 78250
20e. Method of Disposition: 1☐ Buriel 2☐ Cremation 3☐ Removal from State 4☒ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place):
Dete:
20c. Location - City or Town, Stete:
21. Signatura of Funerel Service Licensee: Ronald S. Wade, Director
22. Name end Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiretory arrast, shock, or heert feilure. List only one ceusa on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disaase or condition resulting in death)
e. Congestive Heart Failure — Three Years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete causa. Entar Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Bilateral Pneumonia

23b. Did tobacco use contributa to the cause of death? 1☒ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) and manner as eteted. 2☐ **Medical Examiner**: On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(a) and menner steted.

29b. Signeture and title of certifier
29c. License number: D 33280
29d. Date signed (Month, Day, Year): January 8, 1997

30. Name and eddress of peraon who completed cause of death (Item 23e) (Type, Print): Dr S. Gupta, Johnson Heights Medical Bldg., Cumberland, MD 21502

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Year): JAN 13 1997
32. Registrer's Signature: Waldon-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IYRAN L. BETTER
2. Date of Death: Month JAN Day 5 Year 97
3. Time of Death: 10:15 AM
4a. Facility Name (If not institution, give street and number): BonSecours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-62-5428
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec. 18, 1954
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 626 Wicklow Rd.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Presser
16b. Kind of Business/Industry: Dry Cleaners

17. Father's Name (First, Middle, Last): Johnnie McFadden
18. Mother's Name (First, Middle, Maiden Surname): Olivia Kenslaw

19a. Informant's Name/Relationship (Type, Print): Darryl Better/ brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3706 Reisterstown Rd Balto., MD 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem Park
Date: 1/8/97
20c. Location - City or Town, State: Balto., Md

21. Signature of Funeral Service Licensee: James A Morton
22. Name and Address of Facility: James A. Morton & Sons Funeral Home 1701 Laurens St. BAlto., MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS WITH MULTI ORGAN FAILURE

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. MALNUTRITION

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Obeze MD
29c. License number: D41430
29d. Date signed (Month, Day, Year): JAN 6TH 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 821 N. EUTAW ST #407 BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0046-510
jhm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27 per MEO G-744 2/19/97 rab

Certificate of Death

Reg. No. 97 00415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TONNALEE CLOUD
2. Date of Death Month Day Year: JANUARY 03, 1997
3. Time of Death: 06:35 AM
4a. Facility Name (If not institution, give street and number): JOHN HOPKINS BAYVIEW HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-45-8708
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Yaar Months: 10 Days: 15; If Under 24 Hrs. Hours: Min.:
8. Data of Birth (Month, Day, Year): Feb. 17,1996
9. Birthplaca (State or Foreign Country): Maryland

Usual Residance of Dacedant

10a. Stata: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 333 Imla St.
10f. Zip Coda: 21224
10g. Citizan of What Country?: U.S.A.

11. Meritel Stetus: 1☒ Naver Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U,S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grada compleated)
Elamentery/Secondary (0-12): 0
College (1-4or 5+): N/A
16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired): N/A
16b. Kind of Busnass/Industry: N/A

17. Fathar's Nama (First, Middla, Last): Garland M. Cloud
18. Mothar's Name (First, Middla, Maiden Surneme): Patricia L. Southard

19a. Informant's Name/Ralationship (Typa, Print): Mrs. Patricia L. Southard
19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code): 333 Imla St. Baltimore,Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cemafary, cramatory or othar placa): Moreland Memorial Cem.
Data: 1/8
20c. Location - City or Town, Stata: Baltimore,Md.

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: Hartley Miller Funeral Home 7527 Harford Rd, Balto.,Md. 21234

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha deeth. Do not anter tha moda of dying, such as cardiac or respiretory arrast, shock, or haart feilura. List only one ceusa on aach line.

Approximata Intarval Batween Onsat and Death

Immediata Cause (Finel disaasa or conditlon resulting in death): a. CONGENITAL ABNORMALITY OF BRAIN

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or Injury that initieted avants resulting in deeth) Last:
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yas 2☐ No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☑ Yas 2☐ No

25. Was case rafarrad to medical exeminar? 1☒ Yas 2☐ No
26. Placa of Death (Check only ona) Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 8☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifiar (Check only one): 1☐ **Certifying Physician:** To tha best of my knowledga, death occurred at tha time, dete end placa, and dua to tha ceuse(s) end mannar as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, deta and place, and dua to the ceusa(s) and mannar statad.
29b. Signature end tilla of certifier: [signature]
29c. Licansa number: OCME
29d. Data signed (Month, Day, Year): JANUARY 03,1997

30. Name and addrass of person who completed causa of deeth (Item 23a) (Type, Print): MARY DEION A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: [signature] Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#24a RER DOC. 1-13-97 FILM#G743 J.A. **Certificate of Death**

Reg. No. 97 00416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MONROE CORNISH.

2. Date of Death: Month JANUARY Day 03 Year 1997

3. Time of Death: 15:07 HRS

4a. Facility Name (If not institution, give street and number): LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215 32 5806

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 20, 1934

9. Birthplace (State or Foreign Country): md

Usual Residence of Decedent

10a. State: md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3809 Ridgewood Ave

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1952 thru 1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Anne Arundel Co. School

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Oliver Cornish

19a. Informant's Name/Relationship (Type, Print): Patricia Cornish - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3809 Ridgewood Ave Balto, md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Garrison Forest vet

Date: 1/8/96

20c. Location - City or Town, State: owing mills, md

21. Signature of Funeral Service Licensee: Shannon Stokes

22. Name and Address of Facility: March & H. West 4300 Wabash Ave

To Be Completed by Funeral Director

Physician /Medical Examiner

20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIOPULMONARY ARREST.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. MYOCARDIAC INFARCTION

Due to (or as a consequence of):
c. METASTATIC CANCER.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Abi Nigel Sosan MD.

29c. License number: BS 3836270

29d. Date signed (Month, Day, Year): JANUARY 03 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABI NIGEL SOSAN. LIBERTY MEDICAL CENTER, BALTIMORE MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 18 Rev 6/95

97-0017-510
CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 5 per FH G-743 1-23-97 eoh

Certificate of Death

Reg. No. 97 00417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIE M. CARMICHAEL
2. Date of Death (Month, Day, Year): JANUARY 01, 1997
3. Time of Death: 2050PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL E.R.
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: NA

Funeral Director

5. Social Security Number: 240-52-9221
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1936
9. Birthplace (State or Foreign Country): N.C

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 831 N. Woodington Road
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant
16b. Kind of Business/Industry: Pleasant Manor Nursing Home

17. Father's Name (First, Middle, Last): Willie D. McMillan
18. Mother's Name (First, Middle, Maiden Surname): Lucy Mae Allsbook

19a. Informant's Name/Relationship (Type, Print): James Murchinson - Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 831 N. Woodington Road Baltimore, MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 1-6-97
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 02, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature:

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 5.10e.19b per F.H. G-744 2/14/97 reb **Certificate of Death**

Reg. No. 97 00418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul William DAVIS

2. Date of Death: Month January Day 7 Yaar 1997

3. Time of Death: 4:10 PM

4a. Facility Name (If not institution, giva street and number): Bellforest Nursing Home

4b. City, Town, or Location of Death: Forest Hill

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 229-20-2792 ~~227-44-1475~~

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/18/1925

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore Co.

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 1732 ~~Dreewood~~ DEARWOOD Court

10f. Zip Code: 21040

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): James Davis

18. Mother's Nama (First, Middle, Maidan Surnama): Ella Davis

19a. Informant's Name/Reletionship (Type, Print): Iris Davis/Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 1732 ~~Dreewood~~ DEARWOOD Ct. Edgewood, Maryland 21040

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Community Baptist Church Cemetery

Date: 1/11/97

20c. Location - City or Town, State: Joppa, Maryland

21. Signature of Funeral Service Licensee: Hari P. Close

22. Nama and Address of Facility: William C. Brown Community Funeral Home 1206 W. North Ave, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory failure — 1 week

Due to (or as a consequence of): b. Emphysema — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case refarred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Jerbi

29c. License number: D28339

29d. Date signed (Month, Day, Year): January 8, 1997

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): LINDA FRESCOTT 1016 Wheelwood Rd Belair MD 21015

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Julia Harrison-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE B. DOWELL
2. Date of Death Month Day Year: JANUARY - 9 - 1997
3. Time of Death: 4:35 PM
4a. Facility Name (If not institution, give street and number): Gilcrest G.B.M.C.
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 083-07-4916
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-17-1909
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 612 Bosley Ave.
10f. Zip Code: 21204
10g. Citizen of Whet Country?: U. S. A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: WWII
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor Of Drama
16b. Kind of Businass/Industry: Goucher College
17. Fathar's Neme (First, Middle, Lest): David Joseph Dowell
18. Mother's Name (First, Middle, Meiden Surname): May Kelly
19a. Informant's Name/Relationship (Type, Print): Michael B. Dowell (Nephew)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 368 N. Main Street, Hudson, Ohio 44236
20a. Method ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Gate Of Heaven Cemetery
Date: 1-13-97
20c. Location - City or Town, State: Hawthorne, New York
21. Signeture of Funeral Service Licensee: ▶ Wallace S. Brooks, Jr.
22. Neme and Address of Fecility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications thet caused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or haart tailure. Liat only one causa on each lina.

Approximeta Interval Batween Onset and Death

Immediata Cause (Final disease or condition resulting in death)
a. metastatic colon cancer — 9 months
Due to (or as e consequance ot):
Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or injury that initiated avents resulting in daeth) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: Congestive heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Daath (Check only one): Hospital: 1☐ inpatiant 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) HOSPICE

27. Manner ot Daeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury (Month, Day Year): NA
28b. Time ot injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office buiiding, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at tha time, date and piece, and due to tha cause(s) and manner as stated. 2☐ **Medical Examinar:** On the basis ot examination and/or investigation, in my opinion, deeth occurrad et the time, deta and piece, and dua to the ceuse(s) and menner stated.

29b. Signature and title of certifier: ▶ N Anthony Riely
29c. License number: D25205
29d. Dete signed (Month, Day, Yeer): January 9, 1997

30. Name and address ot person who completed cause of death (Item 29a) (Type, Print): Anthony Riely, M.D.

State Registrar

31. Dete filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: ▶ Linda Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WRC
97-0178-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00420
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES ELIOPOULOS
2. Date of Death (Month, Day, Year): JAN. 10, 1997
3. Time of Death: 7:10 AM
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL BAYVIEW
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-82-8217
8. Sex: 1☒M 2☐F
7. Age *(in yrs. last birthday)*: 21 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 9, 1975
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 522 Rappolla Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembler
16b. Kind of Business/Industry: Cabinet Manufacturing

17. Father's Name *(First, Middle, Last)*: Gus Eliopoulos
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Courtales

19a. Informant's Name/Relationship *(Type, Print)*: Gus Eliopoulos, father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 509 Umbra Street, Baltimore, Md. 21224

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery
Date: 1-14-97
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Ann S. Matthews
22. Name and Address of Facility: Matthews Funeral Home, 3021 Eastern Avenue, Baltimore, Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Gunshot wound of the head	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 1-6-97
28b. Time of Injury: 1937 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Subject was shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Residence
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 522 Rappolla Street Baltimore City, Maryland

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JAN. 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00421

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FAITHOLIVE E. EDWARDS
2. Date of Death Month: JANUARY Day: 9 Year: 1997
3. Time of Death: 6:26 P
4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare Nursing Home
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles Co.

Funeral Director

5. Social Security Number: 340-14-3400
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 26, 1922
9. Birthplace *(State or Foreign Country)*: Chicago, Ill.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles Co.
10c. City, Town or Location: LaPlata
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1 Magnolia Drive
10f. Zip Code: 20646
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service
16b. Kind of Business/Industry: Food Service
17. Father's Name *(First, Middle, Last)*: George Buell
18. Mother's Name *(First, Middle, Maiden Surname)*: Ann Kone
19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Patricia Coronel (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 402 Bland Drive Indian Head, Maryland 20640
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery — Date: 01/13/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Jeffrey L. Gair
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ARTERIOSclerotic Cardiovascular Disease

Due to (or as a consequence of):
b. Ischemic Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart failure
Chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: Maryland D46241
29d. Date signed *(Month, Day, Year)*: 1/10/97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROMALDO DE SOUZA. MD 5021 SEMINARY Rd. Suite 106 ALEXANDRIA VA 22311

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

97 00422

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUSSELL FALK			2. DATE OF DEATH (Month, Day, Year): January 8, 1997	3. TIME OF DEATH: 10:28 PM
4. SOCIAL SECURITY NUMBER: 214-22-3612	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 08/31/1925	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3835 Lyndale Avenue		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Social Security Admin.	
17. FATHER'S NAME (First, Middle, Last): David A. Falk		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie L. Lockmiller	
19a. INFORMANT'S NAME (Type/Print): Paul Falk	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Greentree Drive Phoenix, Maryland 21131		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Immanuel Lutheran Cem. DATE: 1/13/97	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Ruck Jr.	22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md 21204		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	1 hour
	DUE TO (OR AS A CONSEQUENCE OF): HASCVD	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Angina	1 week
	DUE TO (OR AS A CONSEQUENCE OF): HASCVD	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia / atherosclerosis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gerald N. Maggid M.D.	29c. LICENSE NUMBER: D06973	29d. DATE SIGNED (Month, Day, Year) ▶ 1/10/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gerald N. Maggid, M.D. 8100 Harford Rd.

31. DATE FILED (Month, Day, Year): JAN 13 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00423

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Greene
2. Date of Death — Month: January Day: 8 Year: 1997
3. Time of Death: 3:30 pm
4a. Facility Name (If not institution, give street and number): Joseph Ritchie Hospice
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-22-0196
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-16-1925
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1605 Woodbourne Avenue
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th; College (1-4or 5+): 2nd
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Divison Chief
16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): John T. Strokes, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Curtis

19a. Informant's Name/Relationship (Type, Print): Annette E. Phillips/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1605 Woodbourne Ave, Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Crownsville Veteran Cem
Date: 11/15/97
20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: ▶ Hai C Cole
22. Name and Address of Facility: William C. Brown Community Funeral Home, 1206 W. North Ave, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Arrest	3-5 min
Due to (or as a consequence of): b.	CA Metastses	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Breast CA	5 yrs
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify): Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph A. Stephens MD
29c. License number: D11457
29d. Date signed (Month, Day, Year): 1/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph A. Stephens MD 1616 Bolton St. Baltimore MD 21217

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00424

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul GERVASI

2. Date of Death Month Day Year: January 10, 1997

3. Time of Death: 11:56 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-07-9148

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 1,1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7 Edgewater Terrace

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 8 | Collage (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use ratired)*: Crane Operator

16b. Kind of Business/Industry: Bethlehem Steel Corp.

17. Father's Nama *(First, Middle, Last)*: Michael G. Gervasi

18. Mother'a Name *(First, Middle, Maiden Surname)*: Natale DiPrima

19a. Informant's Name/Ralationship *(Type, Print)*: Phoebe Gervasi (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7 Edgewater Terrace Essex, Md. 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cramatory or other place)*: Gardens Of Faith Cemetery

Date: 1/14/1997

20c. Location - City or Town, State: Baltimore Co., Md.

21. Signature of Funeral Servica Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Batween Onsel and Death

Immediate Cause (Final disaase or condition resulting in death): a. Massive Pulmonary Edema — 3 Hours

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last:

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Atherosclerosis

Part II. **Other eignificant conditions** contributing to daath but not resulting in tha undarlying ceuse given in Part I.: Lung Cancer

Advanced Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yee 2 [X] No

24b. Were autopsy findings availabla prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese raferred to medicel examiner? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be detarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, straet, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Physician:** To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha causa(s) and manner statad.

29b. Signature and title of certifier: [signature] M.D

29c. License number: D01461

29d. Date signed *(Month, Day, Year)*: January 11,1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Gunta Wheeler MD. 9600 Franklin Square Dr. Balto, Md. 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00425

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma C. Gross

2. Date of Death Month / Day / Year: 01 / 12 / 97

3. Time of Death: 7.50 AM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Ruxton

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 219-10-6376

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 24, 1914

9. Birthplace *(State or Foreign Country)*: Ft. Calhoun, Neb.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 1610 York Road

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Martin Schneemeyer

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Gross

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Otto M. Gross (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1610 York Road Lutherville, Md. 21093

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gard. — Date: 01/16/97

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair

▶ Jeffrey L. Gair

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure with Pulmonade — >5 years

Due to (or as a consequence of):

b. Chronic obstructive lungs disease — >5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes Mellitus, Type II — >10 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D42736

29d. Date signed *(Month, Day, Year)*: 1-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7600 Osler Drive Towson Md 21204

31. Date filed *(Month, Day, Year)*: JAN 13 1997

State Registrar: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 00426

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Raymond Greener
2. DATE OF DEATH (Month, Day, Year): January 9, 1997
3. TIME OF DEATH: 10:24 AM
4. SOCIAL SECURITY NUMBER: 213-03-2466
5. SEX: 1 ☐ M 2 ☐ F — X
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): April 4, 1910
8. BIRTHPLACE (State or Foreign Country): Baltimore, Maryland
9a. FACILITY NAME (If not institution, give street and number): Westminster Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Westminster
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 102 Timber Ridge Road Apartment 201
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Editorial Artist
16b. KIND OF BUSINESS/INDUSTRY: Newspaper
17. FATHER'S NAME (First, Middle, Last): John Frederick Greener
18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Cassily
19a. INFORMANT'S NAME (Type/Print): Nora B. Crushong
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2101 Bethel Road Finksburg, MD 21048
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery — DATE: 1/13/97
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian A. Willem — ▶ Brian A. Willem
22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, MD 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA OF LUNG WITH METASTASIS	18 MO.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel I Weliver M.D.
29c. LICENSE NUMBER: D11496
29d. DATE SIGNED (Month, Day, Year): ▶1-9 97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL I WELLIVER MD 912 WASHINGTON RD WESTMINSTER MD 21157
31. DATE FILED (Month, Day, Year): JAN 13 1997
32. REGISTRAR'S SIGNATURE: Tina Davidson-Ronsella

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maxine E GRIFFITH
2. Date of Death (Month, Day, Year): January 9, 1997
3. Time of Death: 9:05 am
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 227-28-6638
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 17, 1929
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4119 Eder Road
10f. Zip Code: 21222
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Not Known Simmons
18. Mother's Name (First, Middle, Maiden Surname): Irene Swecker

19a. Informant's Name/Relationship (Type, Print): Mr. Ronald C. Griffith/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4119 Eder Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. | Date: 1/11/1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Myelofibrosis	1 Year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D45475
29d. Date signed (Month, Day, Year): 1-9-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mohammad Rahnama M.D. 19 Fontana Lane, #102 Baltimore, Maryland 21237

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Olaf Leland Hupp
2. Date of Death (Month, Day, Year): January 9 1997
3. Time of Death: 7:25 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Baltimore, Md.
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 291-14-1843
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 21 1918
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Baltimore Co. Maryland
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3311 Acton Road
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Manley Webster Hupp
18. Mother's Name (First, Middle, Maiden Surname): Cleo McHenry

19a. Informant's Name/Relationship (Type, Print): Helen Hupp
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3311 Acton Road, Baltimore, Md. 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Cemetery — Date: 1/13/97
20c. Location - City or Town, State: Baltimore Co Md
21. Signature of Funeral Service Licensee: Doug D Smith
22. Name and Address of Facility: Hartley Miller Funeral Home 7527 Harford Rd. Baltimore Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Congestive Heart Failure	4 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Dilated Cardiomyopathy	5 yrs
Due to (or as a consequence of):		
c.	Ischemic Heart Disease.	10 yrs
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Refractory Anemia.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael D. Suter MD
29c. License number: D44604
29d. Date signed (Month, Day, Year): 1/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael D. Suter MD 8100 Harford Rd Balto MD 21234

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Madison Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Item1 1-13-97 FilmG743 W.H.Per Doctor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00429

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Yaar	3. Time of Death
~~Harriett~~	Harriet	Hack	JANUARY 3, 1997	5:57 A.M.

4a. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
THE JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
399-14-9736	1☐ M 2☒ F	69 Yrs.			JAN. 4,1927	ILLINOIS

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WISCONSIN	OZAUKEE	MEQUON	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10018 KIRKLAND COURT	53092	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Maidan Surnama)
HENRY B. SIEGEL	CELIA SAFER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. JOANNE HYTKEN (DAUGHTER)	727 EAST DAISY LANE FOX POINT, WI 53217

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	SPRING HILL	1-5-1997	MILWAUKEE, , WI

21. Signatura of Funaral Service Licensee	22. Name and Address of Facility
▶ Ellenard Levinson	SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. endocarditis	10 days
	Due to (or as a consequance of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of death?
1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Was casa referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ MD	RES-000	1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Lili Barouch

Tower 110, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 13 1997	▶ Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CONSTANCE HENRY
2. Date of Death Month Day Year: JANUARY 1 1997
3. Time of Death: 6:31 am
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-24-1952
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-10-1927
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: Balto
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 D Slate Hearth Court
10f. Zip Coda: 21117
10g. Citizen of What Country?: U.S.A

11. Maritai Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeper
16b. Kind of Business/Industry: UnKnown

17. Father's Name (First, Middle, Last): William Henry
18. Mother's Name (First, Middle, Meiden Surname): Octavia White

19a. informent's Name/Relationship (Type, Print): Sandra Henry - Sistu
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2 D Slatehearth ct Owings Mills, Md 21117

20a. Mathod of Disposition: 1☒ Buriai 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Druid Ridge Cemetery
Date: 1-6-97
20c. Location - City or Town, Stata: Baltimore, md

21. Signature of Funeral Service Licensee: ▶ Gladys Ward
22. Name and Address of Facility: March E. H. West 4300 Wabash Avenue Balto Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart faliure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. LUNG CANCER
Due to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Dey Year)
28b. Tima of injury M
28c. injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piaca, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifiar: ▶ John Theodore
29c. License number: D14165
29d. Date signed (Month, Day, Year): 1/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger Theodore GBMC

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: ▶ L. Watson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00431

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MABEL O. HICKMAN
2. Date of Death Month JAN. Day 9, Year 1997
3. Time of Death: 4:30 AM
4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON, MARYLAND
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-01-1793
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 6, 1906
9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 800 Southerly Rd.
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Trucking Business

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Christena O'Connor

19a. Informant's Name/Relationship *(Type, Print)*: Mary Mabe/cousin
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8369 Montgomery Run Rd. unit K Ellicott City, Md. 21043

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* Entombment
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Dulaney Valley Mem. Gdns. | Date: 1/11/97
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ENCEPHALOPATHY
Due to (or as a consequence of):
ELECTROLYTE IMBALANCE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
RENAL FAILURE
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
UROSEPSIS
DEHYDRATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated.
29b. Signeture and title of certifier:
29c. License number: D 37254
29d. Date signed *(Month, Day, Year)*: 1-9-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BOON P. LIM, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Georg Johnson
2. Date of Death: Month Jaiwary Day 7 Year 1997
3. Time of Death: 4:00AM
4a. Facility Name (If not institution, give street and number): 1740 E. Lafayette Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-16-2567
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 4, 1926
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: N?A
10c. City, Town or Location: BALTO
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1740 LAFAYETTE AVE
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAUNDRY WORKER
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): CLARENCE ROWE
18. Mother's Name (First, Middle, Maiden Surname): MITTE LEE

19a. Informant's Name/Relationship (Type, Print): ELLEEN HARVEY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 PALMETTO DR EDGEWOOD, MD 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE CEM
Date: JAN 10 1997
20c. Location - City or Town, State: BALTO, MD

21. Signature of Funeral Service Licensee: Katherine Betts
22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Heart Disease
Due to (or as a consequence of): Diabetes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: H/o Cerebral Vascular Disease; Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. D. Holmes MD
29c. License number: D46676
29d. Date signed (Month, Day, Year): Janvary 9 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michaelle Halaby Holmes, Belair Road Family Health Center, 3301 Belair Road, Baltimore MD 21213

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maggie K. Jones
2. Data of Death Month: January Day: 11 Year: 1997
3. Time of Death: 7:35 P.M
4a. Facility Name (If not institution, give street and number): 122 Wesley Avenue
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Balto

Funeral Director

5. Social Security Number: 223-92-7673
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-7-1903
9. Birthplace (State or Foreign Country): Va

Usual Residence of Decedent

10a. State: Md
10b. County: Balto
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 122 Wesley Avenue
10f. Zip Code: 21228
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 2yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Joseph Keyes
18. Mother's Name (First, Middle, Maiden Surname): Jennie Bumpus

19a. Informant's Name/Relationship (Type, Print): Mannan Zakia Amin - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 Wesley Avenue Catonsville, Md 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oakland & Pleasant Shade | Date: 1-15-97
20c. Location - City or Town, State: Hampton, Va

21. Signature of Funeral Service Licensee: Gladys Warren
22. Name and Address of Facility: March F. H. West 4300 Wabash Avenue Balto, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Advanced Alzheimer's Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alejandro Mejia D.O.
29c. License number: D08786
29d. Date signed (Month, Day, Year): 1-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEJANDRO MEJIA M.D. 405 Frederick Rd Balto. 21228

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

14

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00434

FilmG743 item 3 per MEO 1-22-97 rja

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Joseph Kaminski

2. Date of Death Month Day Year: January 8, 1997

3. Time of Death: ~~12~~ 7:15 AM

4a. Facility Name (If not institution, give street and number): 10 Cloverwood Court #103

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-4544

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 16, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10 Cloverwood Court #103

10f. Zip Code: 21221

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8 Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter

16b. Kind of Business/Industry: Food Industry

17. Father's Name (First, Middle, Last): John Kaminski

18. Mother's Name (First, Middle, Maiden Surname): Frieda Seader

19a. Informant's Name/Relationship (Type, Print): Audra M. Kaminski/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Cloverwood Ct. #103 Baltimore, MD 21221

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 1/10/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Reed

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — MOMENTS

Due to (or as a consequence of):

b. HYPERTENSION — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yaar):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bernard J. Ruck MD

29c. License number: D14206

29d. Date signed (Month, Day, Year): JAN 08 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERNARD J RUCK MD 59 DUNDALK AVE BALTO MD 21222

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 00435

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doretha King			2. DATE OF DEATH (Month, Day, Year): January 7 1997	3. TIME OF DEATH: 8:10 AM
4. SOCIAL SECURITY NUMBER: 215-74-2354	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC. 5, 1960	8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MD

9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Bayview Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: n/a

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: n/a	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4307 W. FOREST PARK AV.,		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4 or 5+): 2 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unemployed	16b. KIND OF BUSINESS/INDUSTRY: never worked

17. FATHER'S NAME (First, Middle, Last): BAXTER KING	18. MOTHER'S NAME (First, Middle, Maiden Surname): SYLVIA WOODS
19a. INFORMANT'S NAME (Type/Print): SYLVIA JORDAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4307 W. FOREST PARK AV., BALTIMORE, MD

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEM.	DATE: 1-14-97	20c. LOCATION — City or Town, State: LANSDOWNE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Teresa Hg	22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH FH.-1101 E. NORTH AVE.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Mycobacterium avium complex, disseminated	6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Retroviral infection	10 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cytomegalovirus retinitis, Immune thrombocytopenia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart C. Ray M.D.	29c. LICENSE NUMBER: D45308	29d. DATE SIGNED (Month, Day, Year): ▶ January 7, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stuart C. Ray m.d.		
31. DATE FILED (Month, Day, Year): JAN 13 1997	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

D 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY LIPTRAP

2. Date of Death (Month, Day, Year): JANUARY 6, 1997

3. Time of Death: 8:20PM

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-68-6934

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 10, 1929

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1504 Boundry Avenue

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 7 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): William McKinley Jenkins

18. Mother's Name (First, Middle, Maiden Surname): Edna Orgeon Earman

19a. Informent's Name/Relationship (Type, Print): Leroy Liptrap/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1504 Boundry Ave., Capitol Heights, MD 20743

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in-state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Dete:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in deeth) a.	Sepsis	1 week
Due to (or as a consequence of): b.	Respirato Failure	1 week
Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last: Due to (or as a consequence of): c.	Cardiogenic Shock	1 week
Due to (or as a consequence of): d.	COPD.	Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contributs to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner as stated. 2☐ **Medical Examinsr**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier:

29c. License number: D30318

29d. Date signed (Month, Day, Year): 1/7/97

30. Name end addsss of person who completed cause of death (Item 23a) (Type, Print): James Cataveris 3001 Hospital DR Cheverly Md 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00437

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Albert LONGENECKER
2. Date of Death Month Day Year: January 8, 1997
3. Time of Death: 1:45 pm
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-34-1956
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 23, 1938
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6305 Dietz Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Porter
16b. Kind of Business/Industry: Caldor
17. Father's Name *(First, Middle, Last)*: John David Longenecker
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Virginia Smith-Longenecker
19a. Informant's Name/Relationship *(Type, Print)*: Ruth Longenecker (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6305 Dietz Avenue Baltimore Maryland 21206
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [X] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Anatomy Board
Date: 1/8/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Nasopharyngeal Squamous Cell Cancer	4 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Respiratory Failure	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marco Zamora MD
29c. License number: D40819
29d. Date signed *(Month, Day, Year)*: January 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marco Zamora M.D. 9000 Franklin Square Dr. Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signature: Wilson-Randall

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter S. McGee
2. Date of Death: Month Jan. Day 11 Year 1997
3. Time of Death: 2:50 AM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: City

Funeral Director

5. Social Security Number: 214-24-7630
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 7, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 108 Stoney Bar Bluff
10f. Zip Code: 21638
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4 + 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Dept. of Motor Vehicle

17. Father's Name (First, Middle, Last): George Stanley McGee
18. Mother's Name (First, Middle, Maiden Surname): Leah Dixon

19a. Informant's Name/Relationship (Type, Print): Michael B. McGee
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1160 Warner Hall Dr., Virginia Beach, Va. 23454

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Pauls Ch. Cem.
Date: Jan 14, 1997
20c. Location - City or Town, State: Arcadia, Md.

21. Signature of Funeral Service Licensee: H.G. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Ventricular fibrillation — Approx. 12 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Former tobacco abuse
Possible alcohol abuse

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: Daniel J. Konick, M.D.
29c. License number: D32353
29d. Date signed (Month, Day, Year): Jan. 11, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel J. Konick, M.D. 180 Adm. Cochrane Dr., Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Vi Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Phillip Mosmiller Sr.
2. Data of Death Month: JANUARY Day: 9 Year: 1997
3. Time of Death: 7:49 PM
4a. Facility Name (If not institution, give street end number): Lorian Nursing Home
4b. City, Town, or Location of Death: Belcamp
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-07-8534
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-23-10
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2 Spyglass Court
10f. Zip Code: 21093
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Grocery

17. Father's Name (First, Middle, Last): George Mosmiller
18. Mother's Name (First, Middle, Meiden Surneme): Josephine Frank

19a. Informant's Name/Relationship (Type, Print): Mrs. Anne M. Boddiford
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code): same as #10a - 10e

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Parkwood Cem.
Date: 1-13-97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Maryland 21204

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Cerebrovascular disease — 24 years
Due to (or es a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in deeth) Last
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.
Coronary artery disease

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ **Yes** 2 ☐ No 3 ☐ **Probably** 4 ☒ **Unknown**

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and mannar as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. Licensa number: 028339
29d. Date signed (Month, Dey, Year): January 10, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda Frevlich, 1123 Belcamp Rd

State Registrar

31. Date filed (Month, Dey, Year): JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN McGINNIS

2. Date of Death: Month JANUARY Day 6 Year 1997

3. Time of Death: 11:02 PM

4a. Facility Name (If not institution, give street and number): STELLA MARIS AT MERCY

4b. City, Town, or Location of Death: BALTO

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 055-28-9860

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 1, 1934

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTO

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2614 CECIL AVE

10f. Zip Code: 21218

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BEAUTICIAN

16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): RUFUS WILSON

18. Mother's Name (First, Middle, Maiden Surname): F GERTRUDE HUTCHENSON

19a. Informent's Name/Relationship (Type, Print): MIRES MCGINNIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2614 CECIL AVE BALTO, MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM PARK

Date: JAN 11 1997

20c. Location - City or Town, State: ARBUTUS, MD

21. Signature of Funeral Service Licensee: Nathaniel Betts

22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Non Small Cell Carcinoma of Lung — 1½ years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): STELLA MARIS AT MERCY

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A Riseberg MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): January 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David A Riseberg, MD 4077 301 St Paul Place Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00441

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MATTIE LYLES NELSON
2. Date of Death Month / Day / Year: 01 / 08 / 97
3. Time of Death: 2P.M
4a. Facility Name *(If not institution, give street and number)*: 2323 E. PRESTON ST
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 218-22-6469
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN 6 1915
9. Birthplace *(State or Foreign Country)*: STILTON PA.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2323 E PRESTON ST
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10TH / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC
16b. Kind of Business/Industry: HOUSEKEEPING

17. Father's Name *(First, Middle, Last)*: WILLIAM BARBER
18. Mother's Name *(First, Middle, Maiden Surname)*: UNK

19a. Informant's Name/Relationship *(Type, Print)*: JO ANN LEWIS
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 539 LAURENS ST BALTIMORE MD 21217

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MEADOW RIDGE CEMETERY | Date: 01/11/97
20c. Location - City or Town, State: ELKRIDGE MD.

21. Signature of Funeral Service Licensee: ▶ Donald E. Glover
22. Name and Address of Facility: DONALD E. GLOVER FUN. SERVICE 1701 McCULLOH ST 21217

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that ceused the daath. Do not antar the mode of dying, such es cardiac or respiratory errest, shock, or haart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in daath)
a. COPD
Due to (or as a consaquance of):
Sequentially list conditions, if eny, leading to immedieta ceusa. Entar Underlying Cause (Disaese or Injury that Initieted events resulting in death) Lest
b.
Due to (or as e consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determinad
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician**: To the bast of my knowledga, daath occurred at tha time, date and plece, and due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, daath occurred et tha time, data and place, end due to the ceusa(s) end manner steted.
29b. Signature end title of certifier: ▶ Henri Nammour MD
29c. License number: D35890
29d. Date signed *(Month, Dey, Year)*: 01-08-97

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print): HENRI NAMMOUR 827 LINDEN AVE BALTIMORE MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signature: ▶ Lia Davidson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00442

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carolyn Nelson

2. Date of Death Month / Day / Year: January 12 1997

3. Time of Death: 3:30AM

4a. Facility Name *(If not Institution, give street and number)*: The Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-1964

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 26, 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2242 Redthorn Road

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mixologist

16b. Kind of Business/Industry: Nite Club

17. Father's Name *(First, Middle, Last)*: George L. Nelson

18. Mother's Name *(First, Middle, Maiden Surname)*: Carolyn L. Cliffe

19a. Informant's Name/Relationship *(Type, Print)*: Linda Shifflett (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6818 Hopkins Road Middle River, Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Moreland Mem. Park

Date: 1/15/1997

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	two days
Due to (or as a consequence of):	b. renal failure	one month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. breast cancer	one year
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart M. Lubinski MD House officer

29c. License number: D50096

29d. Date signed *(Month, Day, Year)*: January 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stuart M. Lubinski M.D. The Good Samaritan Hospital 5601 Loch Raven BND Baltimore MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nettie R. Pitts
2. Data of Death — Month: January Day: 8 Yaer: 1997
3. Tima of Death: 12:20 PM
4a. Facility Neme (If not institution, give street end number): Johns Hopkins Bayview
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 410-34-0918
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 70 Yrs. — If Under 1 Yaar: Months / Deys — If Undar 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Day, Year): March 23, 1926
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedant

10a. Steta: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 2600 Gray Manor Terrace
10f. Zip Coda: 21222
10g. Citizen of What Country?: United States

11. Maritai Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Giva Yaer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedant's Education (Specify only highast grada compiated) — Elementary/Secondary (0-12): 6 Years — Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Dietician
16b. Kind of Business/Industry: Health Care

17. Fathar's Nama (First, Middle, Last): Joseph Hamilton Norris
18. Mothar's Nama (First, Middla, Maiden Surname): Minnie Mildred Wilson

19a. Informant's Neme/Ralationship (Type, Print): Edith Ann Smiddy/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 2600 Gray Manor Terrace Dundalk, MD 21222

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Steta 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or othar piece): Sacred Heart of Jesus Cem. — Date: 1/13/97
20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funaral Service Licensee: [signature]
22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart feiiura. List only ona causa on each line. — Approximate Interval Between Onset and Death

Immediate Causa (Finai disaasa or condition rasulting in daath)
a. Metastatic Cancer (Oropharyngeal Squamous Cell Carcinoma)
Due to (or as a consequance of):
Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to compiation of ceuse of death? 1☐ Yas 2☐ No

25. Was casa referred to medicel exeminer? 1☐ Yas 2☒ No
26. Placa of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Home 5☐ Rasidence 8☐ Other (Specify)

27. Mennar of Death: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, deeth occurred et tha tima, data and piace, and dua to tha cause(s) end mannar as stated. 2☐ **Medical Examinar:** On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, dete end piace, and dua to the ceuse(s) and mannar stated.
29b. Signature and title of certifiar: [signature] MD
29c. Licensa number: N8640
29d. Data signed (Month, Day, Year): 1/8/97

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print): Jonas J. Gopez Johns Hopkins Bayview

State Registrar

31. Data filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97 00444

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sister Sophia Radford
2. DATE OF DEATH (Month, Day, Year): January 8 1997
3. TIME OF DEATH: 6:00 A. M
4. SOCIAL SECURITY NUMBER: 191 40 5479
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 28, 1908
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4100 Maple Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Halethorpe
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Halethorpe
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4100 Maple Avenue
10f. ZIP CODE: 21227
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nun
16b. KIND OF BUSINESS/INDUSTRY: Religious Order
17. FATHER'S NAME (First, Middle, Last): Thomas J. Radford
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Kutcher
19a. INFORMANT'S NAME (Type/Print): Sr. Pauline Bilbrough
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4100 Maple Avenue Halethorpe, Maryland 21227
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery — DATE: 1/11
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donna M Zaminowski
22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ventricular fibrillation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: 028236
29d. DATE SIGNED (Month, Day, Year): Jan 8, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dorian St. Martin MD 5941 Old Frederick Rd #14 Balt. MD 21229
31. DATE FILED (Month, Day, Year): JAN 13 1997
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

DHMH-16 Rev 1/89

Item5 1-16-97 FilmG743 W.H.Per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ludlow Rose

2. Date of Death: Month Jan Day 5 Year 1997

3. Time of Death: 7:00 Am

4a. Facility Name (If not institution, give street and number): 3915 Callaway Ave

4b. City, Town, or Location of Death: Balto

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 223-14-2313

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 19, 1915

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3915 Callaway Ave

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nanny

16b. Kind of Business/Industry: Private Home

17. Father's Name (First, Middle, Last): John Jackson

18. Mother's Name (First, Middle, Maiden Surname): Naomi Rice

19a. Informant's Name/Relationship (Type, Print): Sherleen Langley - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3745 Dolfield Ave Balto, md 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Macedonia Bpt ch. Cem.

Date: 1/11/97

20c. Location - City or Town, State: Heathsville, Va

21. Signature of Funeral Service Licensee: Shannon Stokes

22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO RESPIRATORY ARREST

Due to (or as a consequence of):

b. DEBILITY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Thomas

29c. License number: D24148

29d. Date signed (Month, Day, Year): 1-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. Rogers Avenue Balto MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Edna Mae Ruckner	January 10, 1997	12:45am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Keswick Multi-Care Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
066-09-2269	1☐ M 2☒ F	91 Yrs.			3-1-1905	New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
700 W. 40th Street	21211	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	4	Statistician	Bell Telephone Lab.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Ruckner	Mary Aberlee

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs Roas R. Halbert (Niece)	145 W. Lafayette Ave. Baltimore, Maryland 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Valleau Cemetery	1-14-97	Ridgewood, New Jersey

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wallace S. Brooks, Jr.	Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	10 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Empty sella - old history of asthma
athero sclerotic vasular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Joseph W Zebley MD	D22334	10 January 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Joseph W ZEBLEY III M.D. 700 W 40th Street Balt. Md 21211

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 13 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00447

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Yvonne Silver

2. Date of Deeth: Month 01 Day 06 Year 97

3. Time ot Death: 1:05am

4a. Fecility Name *(If not institution, give street end number)*: 1913 E. Chase Street

4b. Clty, Town, or Location of Death: Baltimore

4c. County ot Death: NA

Funeral Director

5. Sociel Security Number: 218-48-1818

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 03-07-46

9. Birthplace *(Stete or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: Md.

10b. County: Na

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1913 East Chase Street

10f. Zip Code: 21213

10g. Citizen ot What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Unemployed

17. Father's Name *(First, Middle, Lest)*: Thomas Price

18. Mother's Name *(First, Middle, Melden Surneme)*: Helen Oliver

19a. Informant's Name/Reletionship *(Type, Print)*: Cynthia James

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1214 E. Eager Street Baltimore, Md. 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place ot Disposition *(Neme of cemetery, cremetory or other piece)*: Mt. Auburn Cem. Date: 01-09-97

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: Talbert-Davis

22. Name end Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	coronary artery disease	months
Due to (or as a consequence ot): b.	myocardial infarction	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last — Due to (or es a consequence ot): c.	Anoxic brain damage	months
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy tindings available prior to completion ot cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury *(Month, Dey Year)*

28b. Time ot Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place ot Injury - At home, ferm, street, tactory, offica building, etc. *(Specify)*

28t. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred et the time, date and piece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis ot exemination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certitier: [signature]

29c. License number: D32389

29d. Dete signed *(Month, Dey, Year)*: 1/10/97

30. Name end address of person who completed cause of death (Item 23a): Johns Hopkins Hospital Baltimore MD 21287

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Madge J. Schley

2. Date of Death (Month, Day, Year): January 10 1997

3. Time of Death: 6:04 AM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-05-3978

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 25 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2300 Dulaney Valley Rd.

10f. Zip Code: 21204

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Milton S. Nelson

18. Mother's Name (First, Middle, Maiden Surname): Caroline Engleman

19a. Informant's Name/Relationship (Type, Print): Martin R. Scheve

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7002 Stoneleigh Ct. Baltimore,Md. 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: 1-13-97

20c. Location - City or Town, State: Baltimore,Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home,Inc. 1050 York Rd. Towson,Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D32543

29d. Date signed (Month, Day, Year): 1/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Stromberg,MD 7505 Osler Dr. Towson,Md. 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: ▶ [signature] Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00449

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Otis F. Smith

2. Date of Death — Month: January; Day: 10; Year: 97

3. Time of Death: 4:20 pm

4a. Facility Name *(If not institution, give street and number)*: Gilchrist, 6601 N. Charles Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-12-1902

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Nov. 20, 1914

9. Birthplace *(State or Foreign Country)*: Baltimore, Md.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1616 Pinnter Road

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: News Paper Reporter

16b. Kind of Business/Industry: Journalist

17. Father's Name *(First, Middle, Lest)*: Merle B. Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: May E. Josenhans

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Monna M. Sekyra (Sister)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1616 Pinnter Road Lutherville, Md. 21093

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Hilltop Service Corp. — Date: 01/13/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. colon Ca metastatic to liver — ~1 year.

Due to (or as a consequenca ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

dementia.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopay performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)* — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other *(Specify)* hospice

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bruce Rosenberg

29c. License number: D24121

29d. Date signed *(Month, Day, Year)*: 1/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): BRUCE ROSENBERG 515 FAIRMOUNT AVE TOWSON, MD 21208.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

5X1

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 13 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret B. Sheffer
2. Date of Death: Month 1 Day 11 Year 97
3. Time of Death: 0521
4a. Facility Name (If not institution, give street and number): Deaton Medical Center
4b. City, Town, or Location of Death: Balto.
4c. County of Death: -

Funeral Director

5. Social Security Number: 215-01-6706
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-6-09
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3710 Mt. Pleasant Ave
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 Th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: J.H.H. Home

17. Father's Name (First, Middle, Last): Mc Laughlin
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): David C. Sheffer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1826 Kittyhawk Road. Balto. 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cem
Date: 1-13-97
20c. Location - City or Town, State: Balto. MD.

21. Signature of Funeral Service Licensee: Maria M. Zannino
22. Name and Address of Facility: Joseph N. Zannino, Jr. Funeral Home, 263 S. Conkling St. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Fungemia	1 wk.
Due to (or as a consequence of):		
Sequentially list conditions, If any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last b.	Cellulitis of Right foot	2 wks.
Due to (or as a consequence of):		
c.	Renal insufficiency	?
Due to (or as a consequence of):		
d.	Diabetes mellitus	?

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Mehtani
29c. License number: D34974
29d. Date signed (Month, Day, Year): 1.11.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5865 Robert Oliver Place #121, Columbia, MD 21045

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00451

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Cora Silverthorn

2. Dete of Deeth Month / Day / Yeer: January 8, 1997

3. Time of Death: 3:26 pm

4e. Fecility Neme *(If not institution, give street end number)*: Northwest Hospital

4b. City, Town, or Location of Deeth: Randallstown

4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 228-26-2321A

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 85 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Jan 25, 1911

9. Birthplece *(Stete or Foreign Country)*: VA

Usual Residence of Decedent

10e. State: Md

10b. County: Balto

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 900 Liberty Rd

10f. Zip Code: 21244

10g. Citizen of What Country?: U.S.A

11. Merital Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grade completed)*

Elementary/Secondery (0-12): 8th

College (1-4or 5+): N/A

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Self-Employed

16b. Kind of Business/Industry: Seamstress

17. Fether's Neme *(First, Middle, Last)*: Linwood Fore

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Willie B. Dean

19a. Informent's Neme/Reletionship *(Type, Print)*: Frank Watson - Son

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4610 Old Court Rd Apt A Balto, md 21208

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Cedar Hill Cemetery

Dete: 1/13/97

20c. Location - City or Town, Stete: Anne Arundel Co, md

21. Signeture of Funeral Service Licensee: Gabrielle Cook

22. Neme end Address of Fecility: Mason F. Lit West 4300 Wabash Ave

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

a. Hypotension

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest

b. gastrointestinal bleeding

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeicien:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier

29c. Licensa number: H43974

29d. Data signed *(Month, Day, Yeer)*: January 8, 1997

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Alla Hsieh. Northwest Hospital. Randallstown, Md

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 13 1997

32. Registrar's Signature: Lisa Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00452

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIE SMITH

2. Date of Death Month: JANUARY Day: 8 Year: 1997

3. Time of Death: 0130

4a. Facility Name *(If not institution, give street and number)*: Mercy Hospital

4b. City, Town, or Location of Death: Balto

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-12-3954

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 16, 1912

9. Birthplace *(State or Foreign Country)*: USA

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1510 W. Mosher St. apt 4N

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: mechanic

18b. Kind of Business/Industry: Fulkner motors

17. Father's Name *(First, Middle, Last)*: Sandy Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Griffin

19a. Informant's Name/Relationship *(Type, Print)*: Martha Parrott- Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3701 Parkview Ave apt B Balto, md 21207

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Cedar Hill

Date: 1/13/97

20c. Location - City or Town, State: Anne Arundel Co, md

21. Signature of Funeral Service Licensee: Gabrielle Cook

22. Name and Address of Facility: Mach F.H.-west 4300 Wabash Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL BLEEDING

Due to (or as a consequence of):

b. METASTATIC LUNG CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?: 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?: 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death?: 1☐Yes 2☒No

25. Was case referred to medical examiner?: 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work?: 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T Lorch MD

29c. License number: P06829

29d. Date signed *(Month, Day, Year)*: JANUARY 8 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. LORCH, M.D. 301 ST. PAUL PLACE BALTIMORE MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: Gibson-Randolph

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Braxton D. SUMNER, Sr.

2. Date of Death (Month, Day, Year): January 10, 1997

3. Time of Death: 11:30 Pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 230-10-5928

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 12, 1912

9. Birthplace (State or Foreign Country): VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: CALIFORNIA

10b. County: RIVERSIDE

10c. City, Town or Location: NORCO

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1853 CHEROKEE AVENUE

10f. Zip Code: 91760

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completad)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): TRUCK DRIVING

16b. Kind of Business/Industry: OVERLAND TRANSPORT

17. Father's Name (First, Middle, Last): JAMES EDWARD SUMNER

18. Mother's Name (First, Middle, Maiden Surname): JULIE F. DICKENSON

19a. Informant's Name/Relationship (Type, Print): PEGGY A. DUALAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 1853 CHEROKEE AVENUE NORCO, CALIFORNIA 91760

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: JAN.14 1997

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Alan C. Dunn

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE BALTIMORE, MARYLAND 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 7 days

Immediata Causa (Final disease or condition resulting in daath)

a. Pneumonia

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that Initiated events resulting in daath) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequenca of):

c.

Due to (or as a consequance of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in tha underlying cause given in Part f.: Diastolic Dysfunction

23b. Did tobecco uee contribute to the ceuse of deeth? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa raferred to medical examiner? 1☐ Yes 2☒ No

28. Placa of Daath (Chack only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manpar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datermined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To tha best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and manner as statad. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carol A Lee MD

29c. License number: RD 2112

29d. Date signed (Month, Day, Year): January 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Carol Lee MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clara M. Scheeler
2. Date of Death (Month, Day, Year): January 9, 1997
3. Time of Death: 6:30 AM
4a. Facility Name (If not institution, give street and number): Cromwell Center-Genesis Eldercare
4b. City, Town, or Location of Death: Baltimore, Maryland
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-44-8289
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 15 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Howard
10c. City, Town or Location: Ellicott City, Md
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2605 Sara Beth Court
10f. Zip Code: 21042
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Ernst R. Fischer
18. Mother's Name (First, Middle, Maiden Surname): Sophie J. Berk

19a. Informant's Name/Relationship (Type, Print): Sandra C. Stecker
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2605 Sara Beth Court, Ellicott City Md 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 1/11/97
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Joseph D. Hartley
22. Name and Address of Facility: Hartley Miller Funeral Home 7527 Harford Rd Baltimore Md 21234

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic coronary artery disease

Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Kawalewski
29c. License number: D21022
29d. Date signed (Month, Day, Year): 1-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. KAWALEWSKI MD 8604 HARFORD rd BALTO. MD 21234

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

3

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Julia Davidson-Randall

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Winona STARCK
2. Date of Death (Month, Day, Year): January 9,1997
3. Time of Death: 10:38 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-28-0016
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 23, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10003 Van Winkle Lane
10f. Zip Code: 21220
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - Amarican Indian, Bieck, White, atc. Specify: White

15. Decedent's Educetion (Specify only highast grada completad): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Cafeteria Worker
16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): Henry C. Hupfeld, Sr.
18. Mothar's Name (First, Middle, Maidan Surname): Julia L. Herbst

19a. Informant's Name/Relationship (Type, Print): Mr. Henry C. Hupfeld,Jr. / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 6910 Willowdale Avenue Baltimore, Md. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Parkwood Cemetery
Date: 1/13/97
20c. Location - City or Town, State: Baltimore,Maryland

21. Signature of Funeral Service Licensee: Mark T. Zavoyna
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximata Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Cardiac arrhythmia	2 days
Due to (or as a consequence of):		
Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Lest b.	Cancer lung	2 months
Due to (or as e consequence of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yea 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D18487
29d. Date signed (Month, Day, Year): 1/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr.Myo Thant 9000 Franklin Square Dr. Baltimore,Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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97-0105-510
CMK

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZBIGNIEW SEMENIUK
2. Data of Death Month Day Year: JANUARY 06, 1997
3. Time of Death: 0328AM
4a. Facility Name (If not institution, give street and number): J.H.H. BAYVIEW MEDICAL CENTER E.R.
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-21-5480
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 8/29/1946
9. Birthplace (State or Foreign Country): Poland

Usual Residance of Dacedent

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: N/A
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 4319 Kenwood Ave.
10f. Zip Coda: 21206
10g. Citizan of What Country?: Poland

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowad 4☐ Divorced
12. Was Decedant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedant's Education (Specify only highest grada completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+): +3
16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Window Installer
16b. Kind of Business/Industry: Construction

17. Fathar's Nama (First, Middle, Last): Jan Semeniuk
18. Mothar's Nama (First, Middle, Maiden Surname): Gertruda Kierzkowska

19a. Informant's Name/Ralationship (Type, Print): Violetta Semeniuk Dtr
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 4319 Kenwood Ave Baltimore, MD 21206

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or othar place): St. Stanislaus Cemetery
Data: 1/8/97
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Nama and Address of Facility: David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md 21231

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwean Onsat and Death

Immediate Causa (Final disaasa or condition resulting in daath)
a. Multiple Injuries
Due to (or as a consequence of):
Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in death) Last
b.
Due to (or as a consequanca of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☒ Yas 2☐ No
24b. Wara autopsy findings available prior to compilation of cause of daath? 1☒ Yas 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☐ Natural 2☒ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year): 1-6-97
28b. Tima of Injury: 1015 M
28c. Injury at Work? 1☐ Yas 2☒ No
28d. Dascribe how injury occurred: Passenger in auto accident
28e. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3200 Blk. Moravia Road

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, date and placa, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and placa, and dua to tha causa(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. Licansa number: O.C.M.E.
29d. Data signed (Month, Day, Year): JANUARY 06, 1997

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): J. LAton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00457

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lawrence J. Sebald

2. Date of Death Month: January Day: 9 Year: 1997

3. Time of Death: 1:00 pm

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 12 8936

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 14, 1922

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 8491 Laurel Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: B. & O. Railroad

17. Father's Name *(First, Middle, Last)*: Christopher Sebald

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Hartman

19a. Informant's Name/Relationship *(Type, Print)*: Rose M. Sebald / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8491 Laurel Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Redeemer Cemetery

Date: 1/13/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Gonce

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute respiratory failure

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

Chronic asst by disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D23624

29d. Date signed *(Month, Day, Year)*: 1/9/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Dr. Khandelwal 1600 Crain Highway Suite 201 Glen Burnie, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00458

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Shandrowski

2. Date of Death Month Day Year: January - 11 - 1997

3. Time of Death: 0300

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216 03 3129

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 20, 1920

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 618 Cromwell Street

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: General Refectories

17. Father's Name (First, Middle, Last): Thomas Shandrowski

18. Mother's Name (First, Middle, Maiden Surname): Anna (unknown)

19a. Informant's Name/Relationship (Type, Print): Joseph Shandrowski / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 618 Cromwell Street Baltimore, Maryland 21225

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 1/13/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard E Davis

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiorespiratory Arrest — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Small Cell Carcinoma of Lung — Unknown

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic lymphocytic Leukemia

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T-D PGY II

29c. License number: AS 244 1416 49

29d. Date signed (Month, Day, Year): January-11-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thanh NGUYEN MD - Harbor Hospital Center -

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00459

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Bryan Smith
2. Dete of Deeth — Month: January; Day: 10; Yeer: 1997
3. Time of Deeth: 5.54 Pm
4a. Fecility Neme (If not institution, give street end number): Harbor Hospital Center
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 232 50 0711
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthdey): 63 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Oct. 9, 1933
9. Birthpiece (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 16 W. Talbott Street
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Meritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: Korean Conflict
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12); College (1-4or 5+): 2 years
16a. Decedent's Usuel Occupetion (Give kind of work done dunhg most of working life. DO NOT use retired): Campus Police Officer
16b. Kind of Business/Industry: John Hopkins University
17. Fether's Neme (First, Middle, Last): William Smith
18. Mother's Neme (First, Middle, Maiden Sumeme): Zola Flanagan
19a. Informent's Neme/Reletionship (Type, Print): Evelyn C. Smith / wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code): 16 W. Talbott Street Baltimore, Maryland 21225
20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Meadowridge Memorial Pk.
Dete: 1/14/97
20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signeture of Funerel Service Licensee: Richard E. Davis
22. Neme end Address of Fecility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finai diseese or condition resulting in deeth): e. Cardio Pulmonary arrest — 1 day

Dua to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Entar Underlying Cause (Diseese or Injury that initieted events resulting in daath) Last:
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Melitus; Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date end place, and due to the ceuse(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: Ali Naderi
29c. License number: AS2441614-61
29d. Dete signed (Month, Dey, Year): January, 10, 1997

30. Neme end eddress of person who completed cause of daeth (Item 23e) (Type, Print): Dr. Ali Naderi, Harbor Hospital Center, 3001 South Hanover Street, Baltimore

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 13 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard B. Thomas, Jr.

2. Date of Death: Month January Day 7 Year 1997

3. Time of Death: 8:45 am

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-32-1148

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov.2, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Sandy Spring

10d. Insida City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: Box 3, Doctor Bird Road

10f. Zip Code: 20860

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Contractor

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Richard Bentley Thomas

18. Mothar's Nama (First, Middle, Maiden Sumama): Ethel Farquhar

19a. Informant's Name/Relationship (Type, Print): Nancy Thomas/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 3, Doctor Bird Rd., Sandy Spring, MD

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer — 7 Years

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D14057

29d. Date signed (Month, Day, Year): January 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Emily M.S. Haller, 18101 Prince Phillip Dr

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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ITEM: 20b, PER F.H. FILM G-743
1/13/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00461

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Anzura Rae Luenda Terry
2. Dete of Deeth — Month: January; Dey: 5; Year: 97
3. Time of Deeth: 4:00pm
4a. Feciity Neme *(If not institution, give street end number)*: 4720 Frederick Ave.
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: n/a

Funeral Director

5. Social Securify Number: 124-24-5046
6. Sex: 1☐ M 2☐ F
7. Age *(tn yrs. lest birthdey)*: 67 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Dec. 29, 1929
9. Birthplace *(Stete or Foreign Country)*: NC

Usuel Residence of Decedent

10e. Stete: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 4720 Frederick Ave.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA
11. Meritel Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☐ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* Black
15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 11th; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Custodial Worker
16b. Kind of Business/Industry: Howard Co. Schools
17. Fether's Neme *(First, Middle, Lest)*: James Hockaday
18. Mother's Name *(First, Middle, Meiden Surneme)*: Eva Cooper
19e. Informent's Neme/Relationship *(Type, Print)*: Thelma Frances/sister
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4720 Frederick Ave. Balto., MD 21229
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: KING MEMORIAL PARK ~~Arlington Mem Park~~
Dete: 1/11/97
20c. Location - City or Town, Stete: Baltimore, MD
21. Signeture of Funerel Service Licensee: James A. Morton
22. Neme and Address of Feciity: James A. Morton & Sons 1701 Laurens St. Balto, Md. 21217

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line. — Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Respiratory arrest
Due to (or es e consequence of):
b. Metastic Colon Cancer
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cauee of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☑ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office buiiding, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date and piece, end due to the ceuse(s) end menner steted.
29b. Signeture end titie of certifier: RJ Walsh
29c. License number: D38662
29d. Date signed *(Month, Dey, Yeer)*: 1/6/97
30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Richard J. Walsh 4660 Wilkens Ave. Baltimore, Md. 21229

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 13 1997
32. Registrer's Signeture: Julia Thrasher-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERNA HELEN TUREK
2. Date of Death: Month January, Day 8, Year 1997
3. Time of Death: 11:55PM
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 210-09-2786
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): December 30, 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 214 Ashwood Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Custodial

17. Father's Name (First, Middle, Last): John Vincent
18. Mother's Neme (First, Middle, Maiden Surname): Louise Wotovich

19a. Informent's Neme/Relationship (Type, Print): Sharon Svrjcek/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3576 Mill Green Road Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Greensburg Catholic Cem. Date: 1/13/97
20c. Location - City or Town, State: Greensburg, PA

21. Signature of Funeral Service Licensee: Charles M. Fink
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	2 weeks
Due to (or es a consequence of):		
b.	CONGESTIVE HEART FAILURE	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest: Due to (or es e consequence of): c.	HYPERTENSIVE ARTERIOSCLEROTIC	~10-20 years
d.	CARDIOVASCULAR DISEASE	

Part II. **Other elgnificant conditione** contributing to death but not resulting in the underlying cause given in Part I.: RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Claudia Kroker M.D.
29c. License number: D50040
29d. Date signed (Month, Day, Year): 01.09.1997

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): CLAUDIA KROKER, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040

State Registrar

31. Date filed (Month, Dey, Year): JAN 13 1997
32. Registrar's Signature: Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00463

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Walker

2. Date of Death Month 01 Day 08 Year 97

3. Time of Death: 9:40am

4a. Facility Name *(If not institution, give street and number)*: 1550 Glen Eagle Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-24-8896

6. Sex: XX 1 M 2☐ F

7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-13-32

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2☐ No

10e. Street and Number: 1550 Glen Eagle Road

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4 XX Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: 1st. Class Rigger

16b. Kind of Business/Industry: Md. Shipyard Drydock Union

17. Father's Name *(First, Middle, Last)*: Harry Walker

18. Mother's Name *(First, Middle, Maiden Surname)*: Mariah Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Erda Young

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1550 Glen Eagle Rd. Baltimore, Maryland 21239

20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Cemetery | Date: 01-13-97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Donald [illegible]

22. Name and Address of Facility: Baltimore, Md. 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Metastatic Colon Carcinoma — months

Dua to (or as a consaquance of):

Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2 X No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case rafarred to medical examiner? 1☐ Yes 2 X No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5 X Residenca 6☐ Other *(Specify)*

27. Manner of Death: XX 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mannar as statad. 2☐ **Medical Examinar**: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth Claire Dees MD

29c. License number: D50325

29d. Data signed *(Month, Day, Year)*: January 10, 1997

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): E.C. Dees MD 600 N Wolfe St. Baltimore MD

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: [illegible] Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert E Woods
2. Date of Death Month: January Day: 7 Year: 1997
3. Time of Death: 7:15 pm
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 248-42-3649
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 14, 1930
9. Birthplace (State or Foreign Country): S. CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3565 DUDULEY AVENUE
10f. Zip Code: 212133
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 th | College (1-4or 5+): --
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STEEL WORKER - R.R.
16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Father's Name (First, Middle, Last): PETE WOODS
18. Mother's Name (First, Middle, Maiden Surname): MARY BOYD

19a. Informant's Name/Relationship (Type, Print): SHIRLEY BOOTH
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 519 N. ROSE ST., BALTIMORE, MD 21205

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE CEMETERY
Date: 1-14
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Alvin McDavis
22. Name and Address of Facility: WM. C. MARCH FH.-1101 E. NORTH AVENUE

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stage IV Lung Cancer — 2 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Julie Tinney MD
29c. License number: AT2438946
29d. Date signed (Month, Day, Year): January 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JULIE TINNEY Union Memorial Hospital Baltimore, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: Gloria Davidson-Randall

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00465

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose WEIS

2. Date of Death Month / Day / Year: January 11, 1997

3. Time of Death: 6:45 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-74-2643

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct.10,1907

9. Birthplace *(State or Foraign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residance of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 708 Mace Avenue

10f. Zip Coda: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 8 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Homemaker

16b. Kind of Business/Industry: Home

17. Fathar's Nama *(First, Middla, Last)*: John J. Weis

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Cecelia M. Fischer

19a. Informant's Name/Relationship *(Type, Print)*: Maryrose Scism (Niece)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 708 Mace Avenue Essex, Md. 21221

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Holy Redeemer Cemetery

Data: 1/14/1997

20c. Location - City or Town, Stata: Baltimore

21. Signature of Funeral Service Licensee: Joan T. Bruzdzinski

22. Nama and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Submit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

28a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Pulmonary Edema — 6 Days

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disease or Injury that initiated evants rasulting in daath) Last

b. Myocardial Ischemia

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only ona)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: Sheena Antonio MD.

29c. Licansa number: RD 1926

29d. Data signad *(Month, Day, Yaar)*: 1/11/97

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): Sheena Antonio MD. 9000 Franklin Square Dr. Balto, Md. 21237

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 13 1997

32. Registrar's Signatura: Gisha Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Item4c 1-13-97 FilmG743 W.H.Per F/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLEMENTINE O. WALLACE
2. Date of Death Month: JAN Day: 7 Year: 97
3. Time of Death: 0245
4a. Facility Name (If not institution, give street and number): MERCY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: ~~BALTIMORE~~ N/A

Funeral Director

5. Social Security Number: 220-14-7517
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/15/1917
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1103 E. BELVEDERE AVE
10f. Zip Code: 21239
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: PRIVATE family

17. Father's Name (First, Middle, Last): JAMES SOMMERVILLE
18. Mother's Name (First, Middle, Maiden Surname): MARION ADDISON

19a. Informant's Name/Relationship (Type, Print): JILL LATIMORE, GRANDNIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1303 E. 36th Street BALTIMORE, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE NATIONAL Cemetery | Date: 1/10/97
20c. Location - City or Town, State: BALTIMORE, Maryland

21. Signature of Funeral Service Licensee: ▶ Gary Harris
22. Name and Address of Facility: CHATMAN-HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kevin O. Babb MD
29c. License number: Maryland D47138
29d. Date signed (Month, Day, Year): 1/7/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KEVIN O. BABB 12403 Village Sq. TERR. Rockville MD

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997
32. Registrar's Signature: ▶ Janice Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00467

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louise K WIECZOREK
2. Date of Death Month / Day / Year: 01 / 04 / 97
3. Time of Death: 10a.m.
4a. Facility Name *(If not institution, giva street and number)*: 7410 KNOLLWOOD RD
4b. City, Town, or Location of Death: TOWSON MD
4c. County of Death: BALTO.

Funeral Director

5. Social Security Number: 056-26-2489
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9-16-1910
9. Birthplace *(State or Foraign Country)*: DEL

Usual Residance of Decedant

10a. State: MD
10b. County: BALTO
10c. City, Town or Location: TOWSON
10d. Insida City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 7410 KNOLLWOOD RD
10f. Zip Code: 21286
10g. Citizan of What Country?: USA

11. Meritel Statis: 1☐ Nevar Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forcas?: 1☐ Yas 2☒ No — If Yas, Giva Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yas 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 12 / Collaga (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: SCHOOL LIBRARIAN
16b. Kind of Business/Industry: BALTO CO. EDUCATION

17. Fathar's Neme *(First, Middle, Last)*: WILLIAM HENRY KANE
18. Mothar's Nema *(First, Middle, Meidan Surnama)*: ANNE CECELIA DOUGHERTY

19a. Informant's Neme/Relationship *(Type, Print)*: JILL W TAPSCOTT DGT
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 21030 13205 BEAVER DAM RD COCKEYSVILLE MD

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Ramoval from Stete 4☒ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, cramatory or othar place)*
Data
20c. Location - City or Town, State

21. Signature of Funeral Service Licansaa: Ronald S. Wade Director
22. Nama and Address of Facility: State Anatomy Board 655 West Balt.MD. Baltimore, MD

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complications thet caused tha daath. Do not entar tha moda of dying, such es cardiac or raspiratory errest, shock, or haart failura. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immadiata Causa (Finel disaasa or condition resulting in death)
a. Arrythmia

Dua to (or as a consequance of):
b. Congestive heart failure

Sequantially list conditions, if eny, leading to immediate cause. Enter Undarlying Causa (Disease or injury that initiated events resulting in death) Last
Dua to (or as a consequence of):
c.

Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.
Generalised arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes casa rafarred to medical examinar? 1☐ Yas 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☒ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
26b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
26d. Describe how injury occurred
26a. Place of Injury - At homa, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: E. Nakhuda M.D.
29c. License number: D 15504
29d. Date signed *(Month, Day, Year)*: 01.06.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. Nakhuda M.D., 2300 Dulaney Valley Road, Balt, Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signatura: Wilson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

97-0022-045
B.K.S

ITEM· 28b, PER MED FILM G-744 2/5/97 t.t

ITEMS: 23PART I, II, 27, 28a-f, PER MED FILM g-743 1/14/97 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TYNEISHA WIGFALL
2. Date of Death (Month, Day, Year): JAN. 1, 1997
3. Time of Death: 1256 PM
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL HOSPITAL
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-02-3516
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 13 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 8,1983
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 115 First St.
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grada completed): Elementary/Secondery (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): n/a
16b. Kind of Business/Industry: n/a
17. Father's Name (First, Middle, Last): Ashley Wigfall, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Shiree A. Douglas
19a. Informant's Name/Relationship (Type, Print): Ashley Wigfall, Jr./father
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1013 N. Division St., Salisbury, MD 21801
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or othar place): Macedonia UMC Cemetery
Date: 1/6/97
20c. Location - City or Town, State: Dames Quarter, MD
21. Signature of Funeral Service Licansee: [signature]
22. Name and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not anter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. ASPHYXIA

Due to (or as a consequence of): ASPIRATION OF FOREIGN OBJECT (FOOD)

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: MENTAL RETARDATION

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☐ Netural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-1-97

28b. Time of Injury: NOON M ~~MIDNIGHT~~

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUBJECT CHOKED ON FOOD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 115 1ST STREET SALISBURY, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as steted. 2☒ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of cartifier: Dennis J. Chutenco
29c. Licansa number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 2, 1997

30. Name and address of persan who completed cause of death (Item 23e) (Type, Print): Dennis J. Chutenco 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 13 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George G. Wheeler

2. Date of Death — Month: January Day: 11 Year: 1997

3. Time of Death: 3:55 A.M.

4a. Facility Name (If not institution, give street and number): 717 - 207th Street

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219 74 3370

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 6, 1946

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 717 - 207th Street

10f. Zip Code: 21122

10g. Citizen of Whet Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): none — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Handicaped

16b. Kind of Business/Industry: Never worked

17. Father's Name (First, Middle, Last): Charles Wheeler Sr.

18. Mother's Name (First, Middle, Melden Surname): Catherine Orf

19a. Informant's Name/Relationship (Type, Print): Doris Gavin / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 717 - 207th Street Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Pk.

Date: 1/14/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard E Davis

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Acute Respiratory failure — 2 days

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

b. Pneumonia — 7 days.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebral Palsy.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], M.D.

29c. License number: D45148

29d. Date signed (Month, Day, Year): January 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ricardo J. Osorno 3708 Mountain Road Pasadena, MD 21122

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00470

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JANET WILLIAMS

2. Date of Death Month / Day / Year: JANUARY 11,1997

3. Time of Death: 10:18 a

4a. Facility Name *(If not Institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 237-02-1551

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: june 6, 1954

9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTO

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 1622 FEDERAL ST

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DRIVER

16b. Kind of Business/Industry: CITY S WORKER

17. Father's Name *(First, Middle, Last)*: THOMAS HARRISON

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY WILLIAMS

19a. Informant's Name/Relationship *(Type, Print)*: MARY WILLIAMS

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3807 COOPER LANE HYETTESVILL, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: mt. zion cem

Date: jan 14 1997

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. brain edema and herniation — 6 hours

Due to (or as a consequence of):

b. Intracerebral hemorrhage — 15 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

drug abuse

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A Williams MD

29c. License number: D40041

29d. Date signed *(Month, Day, Year)*: January 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 600 N. WOLFE ST., BALTIMORE, MARYLAND, 21287

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00471

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLOTTE, M WARNER

2. Date of Death Month: JANUARY Day: 10 Year: 1997

3. Time of Death: 5:10 PM

4a. Facility Name *(If not institution, give street and number)*: University of MD Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-40-7349

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 28, 1943

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6024 Locust Ave.

10f. Zip Code: 21061

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Hotel

17. Father's Name *(First, Middle, Last)*: Deyerle Warner

18. Mother's Name *(First, Middle, Maiden Surname)*: Roberta Lambert

19a. Informant's Name/Relationship *(Type, Print)*: Roberta Warner / Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6024 Locust Ave., Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Glen Haven Mem. Pk. Date: January 13, 1997

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, 421 Crain Hwy., S.E., Glen Burnie, MD 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR TACHYCARDIA — 1 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC CARDIOMYOPATHY — 2 weeks

Due to (or as a consequence of):

c. MYOCARDIAL INFARCT — 2 weeks

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: P10239

29d. Date signed *(Month, Day, Year)*: JANUARY 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD CHUANG, MD 22 S. GREENE STREET, BALTIMORE, MD 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

97-184-510
P.C.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00472

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John West JR.
2. Date of Death Month: 01 Day: 10 Year: 97
3. Time of Death: 1622 p.m.
4a. Facility Name *(If not institution, give street and number)*: 2725 Walbrook Avenue Apt. 317
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 229-26-5604
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2-4-27
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10a. Street and Number: 2725 Walbrook Ave. Apt. 317
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 7-10-45 1-7-47
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4 or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver
16b. Kind of Business/Industry: Cab company

17. Father's Name *(First, Middle, Last)*: John West
18. Mother's Name *(First, Middle, Maiden Surname)*: Cleavie Byrd

19a. Informant's Name/Relationship *(Type, Print)*: Katie Smith-Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 280 Gregory Ave. Apt. C/O Passaic, NJ 07055

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest | Date: 1/14/97
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Albert P Wyllie F/H PA 638 N. Gilmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? Inspection 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chute MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 13 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00473

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MARTIN C. ZERHUSEN JR.
2. Dete of Deeth (Month, Day, Yeer): JANUARY 7, 1997
3. Time of Death: 1037AM
4e. Feciiity Neme (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Deeth: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Sociat Security Number: 218 26 1938
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): May 3, 1930
9. Birthplace (State or Foreign Country): Maryland

Usuei Residence of Decedent

10a. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐Yes 2☒No
10e. Streef end Number: 345 Gatewater Landing Apt. 102
10f. Zip Code: 21060
10g. Citizen of Whet Country?: U.S.
11. Maritel Stetus: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☒Yes 2☐No If Yes, Give Yeer or Detes:
13. Was Decedenf of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Raca - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12th; Collegs (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Service Technician
16b. Kind of Business/Industry: M. & G. Industries
17. Fether's Name (First, Middle, Last): Martin C. Zerhusen Sr.
18. Mother's Neme (First, Middle, Maiden Surname): Elsie Ford
19e. Informent's Neme/Reletionship (Type, Print): Angelika Wiese / daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Gerlinger STR. 60 12349 Berlin, Germany
20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial
Dete: 1/13/97
20c. Location - City or Town, State: Finksburg, Maryland
21. Signeture of Funeral Service Licensee: Donna M Zraniewski
22. Name end Address of Fecility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the diseesfs, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth)
e. DISSEMINATED INTERVASCULAR COAGULATION 1 DAY

Due to (or es e consequenca of):
b. PNEUMONIA 5 DAYS

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet intieted events resulting in deeth) Lest
Due to (or es e consequence of):
c. METASTATIC NONSMALL CARCINOMA OF
Due to (or es e consequence of):
d. THE LUNG 6 MONTHS

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?: 1☐Yes 2☐No 3☐Probebly 4☑Unknown

24e. Wes en autopsy performed?: 1☐Yes 2☑No
24b. Were autopsy findings eveileble prior to completion of cause of death?: 1☐Yes 2☑No

25. Wes case referred to medical exeminer?: 1☐Yes 2☐No
26. Place of Deeth (Check only one): Hospitel: 1☑Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Menner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work?: 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Locetion (Street end Number or Rural Route Number, City or Town, State):
29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end pleca, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, death occurred et the time, date and piece, end due to the cause(s) end menner steted.
29b. Signeture end title of certifier: Dan H. Schneider MD
29c. License number: D28221
29d. Dete signed (Month, Day, Yeer): January 7, 1997
30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): DAN H. SCHNEIDER, MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND 21061

State Registrar

31. Dete filed (Month, Day, Yeer): JAN 13 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria Patricia Ahrens

2. Date of Death Month Day Year: January 11, 1997

3. Time of Death: 8:30 P.M.

4a. Facility Name (If not institution, give street and number): 2103 Eastham Road

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 214-22-8286

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 30, 1926

9. Birthplace (State or Foreign Country): Zainesville, OH.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2103 Eastham Road

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 02

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Life Insurance

17. Father's Name (First, Middle, Last): Purl Ansel

18. Mother's Name (First, Middle, Maiden Surname): Axia Knowlton

19a. Informant's Name/Relationship (Type, Print): Mr. Richard B. Ahrens, Sr. (Hus.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2103 Eastham Road Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gard.

Date: 01/14/97

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceusa (Final disease or condition resulting in death)
e. CARDIAC ARRHYTHMIA — 5 min

Due to (or as a consequence of):
b. CORONARY ART. DISEASE —

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CANCER, LUNG, METASTATIC

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. Hoesch

29c. License number: D20390

29d. Date signed (Month, Day, Year): 1-13-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. Hoesch, 9712 Belair Rd

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Gina Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Booker

2. Date of Death: Month JANUARY Dey 10 Yeer 1997

3. Time of Death: 10 18 AM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 062-38-5617

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 6-20-1948

9. Birthplace (State or Foreign Country): N. 4

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2844 Gatehouse Drive

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry: Dept of Corrections

17. Father's Name (First, Middle, Last): James H. Booker

18. Mother's Name (First, Middle, Meiden Surname): Pauline Saddler

19a. Informant's Neme/Relationship (Type, Print): Audrey Booker -wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2844 Gatehouse Drive Balto, md

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Metro Crematory

Dete: 1-15-97

20c. Location - City or Town, State: Catonsville, md

21. Signature of Funerel Servica Licansee: Gladys Warner

22. Neme end Address of Facility: March F. H. West 4300 Wabash Avenue Balto, md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CARDIOGENIC SHOCK — 1 DAY

Due to (or as a consequence of):

b. AORTIC VALVE SURGERY FOR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. PERSISTANT/RECURRENT AORTIC.

Due to (or as a consequence of):

d. VALVE ENDOCARDITIS. — 21 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HISTORY OF SURGERY FOR REPAIR OF COARCTATION OF AORTA 1960

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: L Clyne

29c. License number: D20111

29d. Dete signed (Month, Day, Year): JANUARY 10 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RAJA S. AYASH UNION MEMORIAL HOSPITAL 201 E. UNIVERSITY PKWY BALT, MD 21218.

State Registrar

31. Dete filed (Month, Dey, Year): JAN 14 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00476

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY L. BRILEY
2. Date of Death: Month 1 Day 10 Year 97
3. Time of Death: 2:15AM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-04-4970
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 9, 1922
9. Birthplace (State or Foreign Country): LOUISIANA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1713 APPLETON STREET
10f. Zip Code: 21217
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISPATCHER
16b. Kind of Business/Industry: BALTO CITY POLICE DEPT.

17. Father's Name (First, Middle, Last): CLEVELAND BRADLEY
18. Mother's Name (First, Middle, Maiden Surname): ALFRETTA (MN-UNKNOWN)

19a. Interment's Name/Relationship (Type, Print): WILLA JOHNSON (GIRLFRIEND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 APPLETON ST., BALTIMORE, MD. 21217

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 1-11-97
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 2 wks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dehydration, Dementia, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christie Lanning MD
29c. License number: D32263
29d. Date signed (Month, Day, Year): 1/10/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2000 W Baltimore Balt MD 21223

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANGELO BUSCEMI
2. Date of Death: Month JANUARY Day 10 Year 1997
3. Time of Death: 5:24 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-6725
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 5, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5544 Force Road
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 11/08/51 - 08/07/53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tarezzaro Mechanic
16b. Kind of Business/Industry: Union
17. Father's Name (First, Middle, Last): John Unknown Buscemi
18. Mother's Name (First, Middle, Maiden Surname): Mary Unknown Colorafici
19a. Informant's Name/Relationship (Type, Print): Robert Buscemi/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2862 Campfire Lane, Orlando, Florida 32822
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: 1/14/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	HEART FAILURE	1 MONTH, 18 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	ISCHEMIC CARDIOMYOPATHY	1 YEAR
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: M7387
29d. Date signed (Month, Day, Year): JANUARY 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. EMIL HAYEK, M.D. 600 N. WOLFE STREET, BALTIMORE, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA BEAN
2. Date of Death (Month, Day, Year): JANUARY, 01, 1997
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice @ Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-78-7968
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 20, 1961
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2308 Norfolk Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maid
16b. Kind of Business/Industry: Cleaning Service

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Michael J. Towson/boyfriend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2308 Norfolk St. Baltimore, MD 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 1/11/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACQUIRED IMMUNE DEFICIENCY SYNDROME	~4 years
Due to (or as a consequence of): b.	HIV INFECTION	UNKNOWN
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: F. Ferro MD
29c. License number: D40480
29d. Date signed (Month, Day, Year): Jan. 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FERNANDO V. FERRO, MD 5810 BELAIR RD BALTO., MD 21206

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

(2)

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00479

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JULIAN F. BOSLEY

2. Dete of Death Month / Day / Year: JANUARY 11 1997

3. Time of Death: 4:30 PM

4e. Facility Neme *(If not institution, give street end number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel Co.

Funeral Director

5. Social Security Number: 216-24-4074

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: NOV.30 1928

9. Birthplece *(Stete or Foreign Country)*: West Virginia

Usuel Residence of Decedent

10e. Stete: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limite: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 442 Magothy Bridge Road

10f. Zip Code: 21122

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 9; College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Dairy Clerk

16b. Kind of Business/Industry: Gaint Food

17. Father's Neme *(First, Middle, Last)*: Raymond V. Bosley

18. Mother's Name *(First, Middle, Meiden Surneme)*: Ethel L. Boyce

19e. Informent's Neme/Reletionship *(Type, Print)*: Juanita M. Bosley / wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 442 Magothy Bridge Road Pasadena Md 21122

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lorraine Park

Dete: JAN.15 1997

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funerel Service Licensee: David A Hayes

22. Neme and Address of Facility: McCully Funeral Home of Pasadena 3204 Mountain Road Pasadena, Md. 21122

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respirelory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Left Ventricular Failure — minutes

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Acute Myocardial Infarction — minutes

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpetient 2 ☒ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated. 2 ☐ **Medical Examiner**: On the besis of exeminetion and/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D01828

29d. Date signed *(Month, Day, Year)*: 1/13/97

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): MAX C FRANK MD 7575 Ritchie Hy. Glen Burnie MD 21061

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 14 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EMMA JANE BRICE-McCAULEY

2. Date of Death Month Day Year: JANUARY 01 1997

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): 208 Bar Harbor Road

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel Co.

Funeral Director

5. Social Security Number: 218-16-0900

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 24 1920

9. Birthplace (State or Foreign Country): Balto. MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 208 Bar Harbor Road

10f. Zip Code: 21122

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Anne Arundel Co.

17. Father's Name (First, Middle, Last): William F. Martin, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Clara S. Spicknall

19a. Informant's Name/Relationship (Type, Print): Dr.Harry McCauley/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 Bar Harbor Rd. Pasadena, Md. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory Inc.

Date: JAN.04 1997

20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully Funeral Home of Pasadena 3204 Mountain Road, Pasadena, Md. 21122

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 5 minutes

Due to (or as a consequence of):

b. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Systemic Lupus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M Palmisano MD

29c. License number: D09407

29d. Date signed (Month, Day, Year): 1-3-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): J. F. PALMISANO MD 6608 LOCH RAVEN BLVD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET R. BUTLER
2. Date of Death Month: JANUARY Day: 12 Year: 1997
3. Time of Death: 01:05 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 230-16-6894
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 31, 1922
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore (Baltimore Highlands)
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 2826 Florida Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — It Yes, Give Yaar or Dates:
13. Was Decedant of Hiapanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Assembler
16b. Kind of Business/Industry: Carr Lowery Glass Co.

17. Father'a Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surneme): Stella Mitchell

19a. Intormant's Name/Reletionship (Type, Print): Mr. Frederick G. Hoppe (Pers. Rep.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2829 Florida Ave., Baltimore, Md. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Spacify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk. — Date: 1/15/97
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Kevin E. Ecker
22. Name and Address of Facility: McCully Funeral Home of Brooklyn, 237 E. Patapsco Ave., Balto., Md. 21225-1856

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	ACUTE RESPIRATORY FAILURE.	1 DAY.
Due to (or as a consequence ot): b.	ASPIRATION PNEUMONIA.	1 DAY.
Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Diaaasa or injury that initiated events resulting in deeth) Last — Due to (or es e consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: COPD, DEMENTIA, CHF, PULMONARY EMBOLISM.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner ot Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date ot Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place ot Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best ot my knowledge, deeth occurred at the time, date end place, and due to the cause(a) and manner as stated. 2☐ **Medical Examiner**: On the basis ot examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and titia ot certifier: RESIDENT PHYSICIAN
29c. Licansa number: AS2441614-37
29d. Data signed (Month, Day, Year): JANUARY 12, 1997

30. Neme and address of person who completed cause ot death (Item 23a) (Type, Print): MUHAMMAD N. FIROZ MD. HARBOR HOSPITAL CENTER BALTIMORE MD 21225

State Registrar

31. Dete tiled (Month, Day, Year): JAN 14 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00482

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERBERT BURGESS

2. Date of Death Month: JAN Day: 12, Year: 1997

3. Time of Death: 1:45 A.

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 161-20-7835

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 22, 1927

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 10737 Green Mountain Circle

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Management Analyst

16b. Kind of Business/Industry: Montgomery Co. Govenment

17. Father's Name *(First, Middle, Last)*: Herbert S. Burgess

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Theresa Elam

19a. Informant's Name/Relationship *(Type, Print)*: Jacqueline B. Hall (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10737 Green Mountain Circle Columbia, Maryland 21044

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Cemetery | Date: Jan. 17, 1997

20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: ▶ Ricia Witzke

22. Name and Address of Facility: Witzke Funeral Home, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William Flowers MD

29c. License number: 20784

29d. Date signed *(Month, Day, Year)*: January 12, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William FLOWERS MD 11055 Little Patuxent Columbia MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 14 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00483

Physician /Medical Examiner

1. Decedant's Name (First, Middle, Last): Joseph Lins Burke (Joseph Lins Burke)
2. Data of Death Month: Jan. Day: 2 Yaar: 97
3. Tima of Death: 3324M
4a. Facility Nama (If not institution, give street end number): Holy Cross Hospital
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 533-18-3925
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 76 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Day, Year): Aug.16,1920
9. Birthplaca (State or Foreign Country): Minnesota

Usual Rasidanca of Decedent

10a. Stete: VA
10b. County: N/A
10c. City, Town or Location: Alexandria
10d. Insida City Limits: 1☒Yas 2☐No
10e. Straet end Numbar: 1316 . Ivanhoe Street
10f. Zip Code: 22304
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowad 4☐Divorcad
12. Was Decedant Evar in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1☐Yas 2☒No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decadant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / Collega (1-4or 5+): 4
16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector General
16b. Kind of Business/Industry: U.S.State Department

17. Fathar's Name (First, Middle, Last): Joseph Darwin Burke
18. Mother's Nama (First, Middle, Maiden Surname): Helen Lins

19a. Informant's Name/Ralationship (Type, Print): Betty H. Burke wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 Ivanhoe St. Alexandria, VA 22304

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other piece): Quantico National Cem.
Date: Jan.6,1997
20c. Location - City or Town, State: Quantico, Va

21. Signatura of Funerel Sarvica Licansea: ▶ Donald M. McDonald
22. Nama end Address of Facility: Everly-Wheatley Funeral Home 1500 W. Braddock Rd. Alexandria,VA

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each lina.

Approximate Intervai Between Onsat and Deeth

Immediata Causa (Final diseasa or condition resulting in daath)
a. Subarachnoid Hemorrhage,
Dua to (or as a consequence of):
b. Subdural Hematoma and
Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last
Dua to (or as a consaquence of):
c. Uncal Cerebral Bleeding — 3 days
Dua to (or as a consaquence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

23b. Did tobacco uae contribute to the cauee of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☐No
24b. Wara autopsy findings available prior to completion of causa of death? 1☐Yas 2☐No

25. Was casa rafarred to medical examiner? 1☒Yas 2☐No
26. Place of Death (Check only one): Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Residanca 6☐Othar (Specify)
27. Mannar of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicida 5☐Panding investigation 6☐Could not be datarminad
28a. Data of Injury (Month, Day Year): Dec 30 96
28b. Tima of Injury: 11 00 AM
28c. Injury at Work? 1☐Yas 2☒No
28d. Describe how injury occurred: Fell
28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify): Hospital Parking lot
28f. Location (Street and Number or Rural Route Number, City or Town, State): Laurel Hosp. Laurel MD

29a. Certifiar (Check only one): 1☐Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☒Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and mannar stated.
29b. Signeture end titie of certifiar: ▶ John Lauber MD
29c. Licensa number: D08546
29d. Date signed (Month, Day, Year): Jan 2 1997 Bethesda MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Lauber 8218 Wisconsin Ave

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997
32. Registrar's Signature: ▶ Linda Davidson-Randello

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00484

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): MARIE BUCHWALD
2. Date of Death: Month Jan, Day 10, Year 1997
3. Time of Death: 1:03pm
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a
5. Social Security Number: 213-09-4812
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months, Days
If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 2, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7854 St.Fabian Lane
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Advertising

17. Father's Name (First, Middle, Last): John Buchwald
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Graf

19a. Informant's Name/Relationship (Type, Print): Adele Moyer/niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7854 St.Fabian Lane Baltimore Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Cemetery
Date: 1/14/97
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Multiple organ failure syndrome	4 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Intra abdominal sepsis	4 weeks
Due to (or as a consequence of):		
c.	Small bowel infarction	4 weeks
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Bokhari MD
29c. License number: D-26594
29d. Date signed (Month, Day, Year): Jan 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. BOKHARI M.D. 100 N. BROADWAY BALTIMORE MD 21231

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00485

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANK J. BLAZEK

2. Data of Death Month Day Yaer: January 13, 1997

3. Time of Death: 07:55 am

4a. Facility Nama *(If not institution, give street and number)*: Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-14-9333

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 15, 1919

9. Birthplace *(Stete or Foreign Country)*: Md.

Usual Residenca ot Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 823 Stags Head Rd.

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- it Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanical Engineer

16b. Kind of Business/Industry: Westinghouse

17. Fathar's Nama *(First, Middle, Last)*: Adolph Blazek

18. Mother's Name *(First, Middle, Maiden Sumame)*: Antonia Unknown

19a. Informent's Neme/Relationship *(Type, Print)*: Mrs. Katherine Blazek/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 823 Stags Head Rd. Towson, Md. 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cemetery, cremetory or othar place)*: Hilltop Service Corp. Data: 1/14/97

20c. Location - City or Town, Stata: Towson, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): a. Hypoxia, cardiac arrythmia — days, hours

Due to (or es e consequence ot): b. Duodenal ulcer — days

Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last

Due to (or as e consequence of): c. Bladder carcinoma — unknown

Dua to (or as e consequenca of): d.

Part ii. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Pert I.

23b. Did tobacco uaa contributa to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yas 2☐ No

25. Was case referrad to medical examiner? 1☐ Yes 2☒ No

28. Placa of Death *(Check only one)*: Hospital: 1☒ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street end Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examinar:** On tha basis ot examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the causa(s) and mannar stated.

29b. Signatura and title of certifier: Rebecca A. Ludwig

29c. License number: D36226

29d. Dete signed *(Month, Day, Year)*: 01/13/97

30. Neme and address ot person who completed cause of death (item 23a) (Type, Print): Rebecca A. Ludwig, M.D. - GBMC 6701 N Charles St., Baltimore MD 21204

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 14 1997

32. Registrar's Signature: Gina Davison-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alma Jane Brown

2. Date of Death: Month January Day 11th Year 1997

3. Time of Death: 2:20 PM

4a. Facility Name (If not institution, give street and number): Joseph Richie Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 238-56-4214

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 24, 1915

9. Birthplace (State or Foreign Country): Vance Co. N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3572 Kingspoint Rd.

10f. Zip Code: 21133

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Aaron Reavis

18. Mother's Name (First, Middle, Maiden Surname): Sophie Floyd

19a. Informant's Name/Relationship (Type, Print): Bertha Greene

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3572 Kingspoint Rd. Randallstown, MD 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ebenezer Church Cem. Greater Ashley Chapel

Date: Jan. 15 1997

20c. Location - City or Town, State: Vaughan, N.C.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.

22. Name and Address of Facility: Skarda F.H. 2829 Hudson St. Baltimore, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiinfarct Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Subdural Hematoma

Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell MD

29c. License number: D42129

29d. Date signed (Month, Day, Year): 1-11-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William McConnell 500 W. University Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daniel Leslie Benner

2. Date of Death (Month, Day, Year): January 11, 1997

3. Time of Death: 11:59 PM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-38-2646

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 22, 1940

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 419 South Folcroft Street

10f. Zip Code: 21224

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly

16b. Kind of Business/Industry: Automobile Manufacturing

17. Father's Name (First, Middle, Last): Henry Julius Benner

18. Mother's Name (First, Middle, Maiden Surname): Mildred Elizabeth Jungblut

19a. Informant's Name/Relationship (Type, Print): Mrs. Brenda J. Benner/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 S. Folcroft St. Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Ht. of Jesus Cem. | Date: 1/14/97

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Reed

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Liver Failure	2 mos
Due to (or as a consequence of): b.	Cirrhosis	2 mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Alcohol Abuse	
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Physician - MD

29c. License number: D44969

29d. Date signed (Month, Day, Year): 1/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Bravy, MD c/o Comprehensive Care 4900 Eastern Ave Balt md 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD BLAKELY

2. Date of Death Month Day Year: JANUARY 10 1997

3. Time of Death: 9:10 P

4a. Facility Name (If not institution, give street and number): LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: CITY

Funeral Director

5. Social Security Number: 242-36-3405

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/02/1927

9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3001 Garrison Boulevard

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Charles Raleigh/admin.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3001 Garrison Boulevard, Balto.,MD 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Western Star Cemetery | Date: 1/15

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Leroy O. Dyett

22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE.,BALTO. 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC CARCINOMA TO LUNG, BONE, LIVER

Due to (or as a consequence of):

c. CARCINOMA OF STOMACH — 1996

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

UPPER GASTROINTESTINAL BLEEDING, HYPERTENSION

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

PARKINSONISM DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D19057

29d. Date signed (Month, Day, Year): JANUARY 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PEDRO E. CORREA LIBERTY MEDICAL CENTER

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-0179-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARLA L. BUTLER
2. Date of Death (Month, Day, Year): JAN. 10, 1997
3. Time of Death: 0312 AM
4a. Facility Name (If not institution, give street and number): 222 NORTH MONTFORD AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-80-7442
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 38 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 22, 1958
9. Birthplace (State or Foreign Country): BALTIMORE, MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 222 N. MONTFORD AE.
10f. Zip Code: 21224
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: DISABLED

17. Father's Name (First, Middle, Last): ROBERT BUTLER
18. Mother's Name (First, Middle, Maiden Surname): JOAN ANDERSON

19a. Informant's Name/Relationship (Type, Print): JOAN M. CASSELL
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 N. MONTFORD AV., BALTIMORE, MD 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cramatory or other place): ARBUTUS MEMORIAL PARK
Date: 1-16
20c. Location - City or Town, State: ARBUTUS, MD

21. Signature of Funeral Service Licensee: ▶ Vanessa Cook
22. Name and Address of Facility: WM. C. MARCHFH.-1101 E. NORTH AE.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AIDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home ☒ Residence 8☐ Other (Specify)
27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stuart A. Radentz, MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 10, 1997

30. Name and address of person who completed cause of death (Item 29e) (Type, Print): DR. RADENTZ 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997
Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie E. Carroll

2. Date of Death Month: JAN. Day: 12 Year: 1997

3. Time of Death: 5:55 pm

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore, Maryland

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-46-9631

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/26/1913

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1906 N. Longwood Street

10f. Zip Code: 21216

10g. Citizen of What Country?: U.SA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Joseph Gray

18. Mother's Name (First, Middle, Maiden Surname): Sophie Penn

19a. Informant's Name/Relationship (Type, Print): James J. Carroll

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3712 Nortonia Road, Baltimore, Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: 1/17

20c. Location - City or Town, State: Arbutus, Maryland

21. Signature of Funeral Service Licensee: Leroy O. Dyett

22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207

Physician /Medical Examiner

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 15 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Perforated viscous — 15 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

right heart failure

renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Szostak

29c. License number: 58626

29d. Date signed (Month, Day, Year): Jan. 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. SZOSTAK, MD Dept of Surgery-University of Maryland Medical Center

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Barbara Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00491

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cynthia Yvonne Chavis

2. Date of Death Month: January Day: 12 Year: 1997

3. Time of Death: 10 30 AM

4a. Facility Name *(If not institution, give street end number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-58-3530

6. Sex: 1☐ M 2☒ F XX

7. Age *(In yrs. last birthday)*: 43 Yrs. If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 6, 1953

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. inaide City Limits: 1☒ Yes 2☐ No XX

10e. Street and Number: 2535 Brookfield Avenue

10f. Zip Code: 21217

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American indian, Black, White, etc. *Specify:* Black

15. Decedent's Edcetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): ; College (1-4or 5+): 2

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed

16b. Kind of Business/Industry: Home Care Provider

17. Father's Name *(First, Middle, Last)*: William Joseph Chavis

18. Mother'a Neme *(First, Middle, Maiden Surname)*: Evelyn Melvin

19a. Informant's Neme/Relationship *(Type, Print)*: daughter Adrienne L. Chavis

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2535 Brookfield Avenue Baltimore, Maryland 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Western Star Cemetery

Date: Jan 16

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ernest R Terry Jr

22. Name end Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, Maryland 21216

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Intra cerebral bleed	2 hours
Due to (or as a consequence of):	b. Septic Embolisation to brain	1 day
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	c. Endocarditis	3 months
Due to (or as e consequence of):	d. Intravenous drug Abuse	3 months

Part ii. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings avelieble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of injury *(Month, Day Year)*

28b. Time of Injury M

28c. injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the beais of examinetion end/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Do

29c. License number: AT248946

29d. Dete signed *(Month, Day, Year)*: January 12 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print): 201 E. University Parkway, Baltimore, Maryland, 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 14 1997

32. Registrar's Signature: ▶ [signature] Lawrence-Randelle

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALICE CATHERINE CHANEY

2. Date of Death (Month, Day, Year): January 13, 1997

3. Time of Death: 8:11 A.M.

4a. Facility Name (If not institution, give street and number): 5006 Plainfield Ave.

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-38-1591

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 3, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decadant

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5006 Plainfield Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): Charles Geisendaffer

18. Mother's Name (First, Middle, Maiden Surname): Catherine Bock

19a. Informant's Name/Relationship (Type, Print): Mrs. Doris A. Cody (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5006 Plainfield Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 1/15/97

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: James J. Gladden

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Balto. Md. 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Coronary occlusion

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward F. Wenzlaff (M.D.)

29c. License number: D11413

29d. Date signed (Month, Day, Year): 1/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward F. Wenzlaff, M.D. 7600 Osler Dr. Towson, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Julia Davidson-Ramirez

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 00493

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MASON B. CAMPBELL

2. Date of Death (Month, Day, Year): JANUARY 11 1997

3. Time of Death: 11:33 AM

4a. Facility Name *(If not institution, give street and number)*: MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-03-0264

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 01, 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1800 RIGGS AVENUE

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: FEB 4, 44 - JAN. 11, 46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 10TH GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARE TAKER

16b. Kind of Business/Industry: CITY RECREATION & PARKS DEPT.

17. Father's Name *(First, Middle, Last)*: JAMES W. CAMPBELL

18. Mother's Name *(First, Middle, Maiden Surname)*: MAMIE MASON

19a. Informant's Name/Relationship *(Type, Print)*: IDA MAE JEFFERSON (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1541 CLIFTON AVE., BALTIMORE, MD. 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEMORIAL PARK | Date: 1-16-97

20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction — Approximate Interval: 2-3 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32158

29d. Date signed *(Month, Day, Year)*: 1/11/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): JYOTIN PARIKH, MD, 821 N. Eutaw St # 407, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 14 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

97-0226-510
ML

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID DORSEY

2. Date of Death (Month, Day, Year): JANUARY 13 1997

3. Time of Death: 11:28 AM

4a. Facility Name (if not institution, giva street and number): 123 W.29th. STREET APARTMENT 9F

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-12-7274

6. Sex: XX 1 M 2 F

7. Age (in yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug.11,1923

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedant

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 123 W. 29th St. 9f

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 XX Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No
If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 Yes 2 XX No Specify:

14. Race - American indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highast grade completed)
Elamentary/Secondary (0-12): 8th
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Hucksters

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Charles Dorsey

18. Mother's Name (First, Middle, Maiden Surname): Cassie Smith

19a. Informant's Name/Relationship (Type, Print): Anthony Dorsey/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 903 Andover Rd. Balto., MD 21218

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): West Liberty Methodist

Date: 1/17/97

20c. Location - City or Town, State: MArriotsville, M

21. Signature of Funeral Service Licensee: James A Morton

22. Name and Address of Facility: James A. Morton & Sons Funeral Home
1701 LAurens St. VAlto., MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each line.

Approximata Intarval Between Onsat and Death

Immediata Cause (Final disaase or condition resulting in death): Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b. Due to (or as a consequance of):

c. Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part i.: ASTHMA

23b. Did tobacco uss contribute to ths causs of death? 1 Yss 2 No 3 Probably 4 XX Unknown

24a. Was an autopsy performed? inspection 1 Yes 2 XX No

24b. Wara autopsy findings available prior to completion of causa of death? 1 Yes 2 No

25. Was case referrad to medical examiner? 1 X Yes 2 No

26. Placa of Death (Check only one)
Hospital: 1 inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 XX Residence 8 Other (Specify)

27. Mannar of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 8 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2 XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Laron Locke MD

29c. License number: O.C.M.E.

29d. Date aigned (Month, Day, Year): JANUARY 13,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY DAVES

2. Date of Death: Month JANUARY Day 9 Year 1997

3. Time of Death: 10:28 AM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 101-20-4840

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 17, 1927

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: NEW YORK

10b. County:

10c. City, Town or Location: BROOKLYN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 406 PARK PLACE

10f. Zip Code: 11238

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH

College (1-4 or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER

16b. Kind of Business/Industry: JEWISH BOARD OF GUARDIANS

17. Father's Name (First, Middle, Last): LEWIS DAVES

18. Mother's Name (First, Middle, Maiden Surname): GENIEVE BROWN

19a. Informant's Name/Relationship (Type, Print): KENDALL MARTIN- NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 HARRISON AVE. ,JERSEY CITY, NEW JERSEY 07304

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): THE EVERGREENS

Date: JANUARY 14, 1997

20c. Location - City or Town, State: BROOKLYN, NEW YORK

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Jr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	TROUSSEAU'S SYNDROME	EIGHT WEEKS
Due to (or as a consequence of): b.	PANCREATIC CANCER	FIVE WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STROKE, BLEEDING DIVERTICULI IN BLADDER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric J. Carr MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC J. CARR, MD JOHNS HOPKINS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Linda Davidson-Randolph

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 00496

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD HARRISON Dailey JR.
2. Date of Death (Month, Dey, Year): January 1, 1997
3. Time of Death: 2139
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 272-36-9814
6. Sex: 1 X M 2 ☐ F
7. Age (in yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): MAY 15, 1943
9. Birthplace (State or Foreign Country): OHIO STEUBENVILLE

Usual Residence of Decedent

10e. State: AL
10b. County: MORGAN
10c. City, Town or Location: DECATUR
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street end Number: RD #2 BOX 400
10f. Zip Code: 35603
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Reca - American indien, Bieck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER
16b. Kind of Business/Industry: RAILROAD

17. Fether's Neme (First, Middle, Last): HAROLD HARRISON DAILEY SR.
18. Mother's Neme (First, Middle, Meiden Surneme): DOROTHY MINOR

19a. Informent's Name/Reletionship (Type, Print): PATRICIA DAILEY
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): RD #2 BOX 400 DECATUR, AL. 35603

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): FORT STEUBEN BURIAL Dete: JAN 6 1997
20c. Location - City or Town, Stete: WINTERSVILLE, OH.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Neme end Address of Feciility: SKARDA FH. 2829 HUDSON ST. BALTO. MD. 21224

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finei disease or condition resulting in deeth)
e. Pneumonia — 24 hrs

Due to (or es e consequence of):
b. Interstitial Lung Disease — 4 weeks

Sequentially list conditions, if eny, ieeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last
c.

Due to (or es e consequenca of):
d.

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Wes case referred to medicai exeminer? 1 ☐ Yes 2 ☑ No
28. Piece of Death (Check only one): Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Deeth: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of injury (Month, Day Year)
28b. Time of Injury M
28c. injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete and piece, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: J Steve Julian MD
29c. License number: 41813
29d. Date signed (Month, Day, Year): 1/2/97

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): J Steve Julian MD 201 Pine Bluff Rd Salisbury MD 21801

State Registrar

31. Date filed (Month, Dey, Year): JAN 14 1997
32. Registrar's Signeture: Linda Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00497

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LUCY ELLINGTON

2. Date of Death Month: JAN Day: 7 Year: 1997

3. Time of Death: 9:17 PM

4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 250-58-6152

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 15, 1915

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1961 W. FAYETTE STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8TH GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSING ASSISTANT

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name *(First, Middle, Last)*: WILLIE GAMBRELL

18. Mother's Name *(First, Middle, Maiden Surname)*: NANNY ROBINSON

19a. Informant's Name/Relationship *(Type, Print)*: LYDIA WRIGHT (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1961 W. FAYETTE ST., BALTIMORE MD. 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: MT. ZION CEMETERY | Date: 1-13-97

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D30272

29d. Date signed *(Month, Day, Year)*: JAN 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS S. MILLER MD BON SECOURS HOSPITAL, BALTIMORE, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 14 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#20a PER F.H. 1-14-97 FILM#G743 J.A.

Certificate of Death

Reg. No. 97 00498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MOZELL G. EVERETT

2. Date of Death Month/Day/Year: JANUARY 9, 1997

3. Time of Death: 12:30 PM

4a. Facility Name (If not Institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-24-3471

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 1, 1910

9. Birthplace (State or Foreign Country): Fla

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2204 Mt. Holly St.

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria

16b. Kind of Business/Industry: Baltimore City Schools

17. Father's Name (First, Middle, Last): Neal Garrison

18. Mother's Name (First, Middle, Maiden Surname): Martha

19a. Informant's Name/Relationship (Type, Print): Diana Everett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2204 Mt. Holly St. Balto, Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 1/13/97

20c. Location - City or Town, State: Balto, md

21. Signature of Funeral Service Licensee: Gabrielle Clark

22. Name and Address of Facility: Mark F. H. West 4300 Wabash Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Laryngeal Cancer

Due to (or as a consequence of):

b. Advanced Cancer of Cervix

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Cardiac ARREST

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 89247

29d. Date signed (Month, Day, Year): 1/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nsekenene Kolongo, M.D. C/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be completed by Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00499

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELIZABETH FALTER

2. Date of Death (Month, Day, Year): JAN. 13, 1997

3. Time of Death: 10:50 AM

4a. Facility Name (If not institution, give street and number): SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-34-9434

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 19, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4408 Camellia Road

10f. Zip Code: 21236-1736

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Penn Fruit

17. Father's Name (First, Middle, Last): Richard Taylor

18. Mother's Name (First, Middle, Maiden Surname): Katherine May

19a. Informant's Name/Relationship (Type, Print): Mrs. Kathleen R. Hall/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4408 Camellia Road Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Joseph Church Cem.

Date: 1/16/96

20c. Location - City or Town, State: Fullerton, Maryland

21. Signature of Funeral Service Licensee: Mark T. Zavoyna

▶ Mark T. Zavoyna

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE — 3 WEEKS

Due to (or as a consequence of):

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

ACUTE RENAL FAILURE

MULTI INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Beatriz P. Dizon, M.D.

29c. License number: D16492

29d. Date signed (Month, Day, Year): January 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Beatriz P. Dizon, M.D., 7620 York Road, Towson, Maryland 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date Filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Julia Faulkner Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 00500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur Grimes

2. Date of Death: Month 1 Day 7 Year 97

3. Time of Death: 944 am

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Systems

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-54-3185

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 46 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6 21 50

9. Birthplace (State or Foreign Country): MARYland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2334 Druid Park Dr

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ROOFER

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): ARTHUR GRIMES

18. Mother's Name (First, Middle, Maiden Surname): RUTH GROSS

19a. Informant's Name/Relationship (Type, Print): CHRISTINE GROSS/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2334 Druid Park Dr. Baltimore md 21215

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 1-10-97

20c. Location - City or Town, State: Baltimore, Md 21229

21. Signature of Funeral Service Licensee: Joseph R. Walter Jr

22. Name and Address of Facility: Unity Funeral Home 108 W. North, Ave Baltimore md 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. electrolyte imbalance

Due to (or as a consequence of):
b. subdural hematoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

end stage renal disease
AIDS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: P100 36

29d. Date signed (Month, Day, Year): 1/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barbara E. Lazio MD 22 S. Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1997

32. Registrar's Signature: Julia Davidson-Randall

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Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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